

PRELIMINARY DRAFT

TEXAS LEGISLATIVE COUNCIL  
Government Code  
Chapter 532  
9/30/22

1	CHAPTER 532.	MEDICAID ADMINISTRATION AND OPERATION IN GENERAL	
2		SUBCHAPTER A. GENERAL PROVISIONS	
3	Sec. 532.0001.	DEFINITION . . . . .	4
4		SUBCHAPTER B. ADMINISTRATION	
5	Sec. 532.0051.	COMMISSION ADMINISTRATION OF MEDICAID . . . . .	4
6	Sec. 532.0052.	STREAMLINING ADMINISTRATIVE PROCESSES . . . . .	5
7	Sec. 532.0053.	GRIEVANCES . . . . .	7
8	Sec. 532.0054.	OFFICE OF COMMUNITY ACCESS AND SERVICES . . . . .	9
9	Sec. 532.0055.	SERVICE DELIVERY AUDIT MECHANISMS . . . . .	9
10	Sec. 532.0056.	FEDERAL AUTHORIZATION FOR REFORM . . . . .	10
11	Sec. 532.0057.	FEEs, CHARGES, AND RATES . . . . .	12
12	Sec. 532.0058.	ACUTE CARE BILLING COORDINATION SYSTEM;	
13		PENALTIES . . . . .	15
14	Sec. 532.0059.	RECOVERY OF CERTAIN THIRD-PARTY	
15		REIMBURSEMENTS . . . . .	18
16	Sec. 532.0060.	DENTAL DIRECTOR . . . . .	18
17	Sec. 532.0061.	ALIGNMENT OF MEDICAID AND MEDICARE	
18		DIABETIC EQUIPMENT AND SUPPLIES	
19		WRITTEN ORDER PROCEDURES . . . . .	18
20		SUBCHAPTER C. FINANCING	
21	Sec. 532.0101.	FINANCING OPTIMIZATION . . . . .	20
22	Sec. 532.0102.	RETENTION OF CERTAIN MONEY TO	
23		ADMINISTER CERTAIN PROGRAMS; ANNUAL	
24		REPORT REQUIRED . . . . .	20
25	Sec. 532.0103.	BIENNIAL FINANCIAL REPORT . . . . .	22

1		SUBCHAPTER D. PROVIDERS	
2	Sec. 532.0151.	STREAMLINING PROVIDER ENROLLMENT AND	
3		CREDENTIALING PROCESSES . . . . .	25
4	Sec. 532.0152.	USE OF NATIONAL PROVIDER IDENTIFIER	
5		NUMBER . . . . .	27
6	Sec. 532.0153.	ENROLLMENT OF CERTAIN EYE HEALTH CARE	
7		PROVIDERS . . . . .	28
8	Sec. 532.0154.	RURAL HEALTH CLINIC REIMBURSEMENT . . . . .	30
9	Sec. 532.0155.	RURAL HOSPITAL REIMBURSEMENT . . . . .	31
10	Sec. 532.0156.	REIMBURSEMENT SYSTEM FOR ELECTRONIC	
11		HEALTH INFORMATION REVIEW AND	
12		TRANSMISSION . . . . .	34
13		SUBCHAPTER E. DATA AND TECHNOLOGY	
14	Sec. 532.0201.	DATA COLLECTION SYSTEM . . . . .	35
15	Sec. 532.0202.	INFORMATION COLLECTION AND ANALYSIS . . . . .	37
16	Sec. 532.0203.	PUBLIC ACCESS TO CERTAIN DATA . . . . .	41
17	Sec. 532.0204.	DATA REGARDING TREATMENT FOR PRENATAL	
18		ALCOHOL OR CONTROLLED SUBSTANCE	
19		EXPOSURE . . . . .	42
20	Sec. 532.0205.	MEDICAL TECHNOLOGY . . . . .	42
21	Sec. 532.0206.	PILOT PROJECTS RELATING TO TECHNOLOGY	
22		APPLICATIONS . . . . .	43
23		SUBCHAPTER F. ELECTRONIC VISIT VERIFICATION SYSTEM	
24	Sec. 532.0251.	DEFINITION . . . . .	44
25	Sec. 532.0252.	IMPLEMENTATION OF CERTAIN PROVISIONS . . . . .	44
26	Sec. 532.0253.	ELECTRONIC VISIT VERIFICATION SYSTEM	
27		IMPLEMENTATION . . . . .	45
28	Sec. 532.0254.	INFORMATION TO BE VERIFIED . . . . .	45
29	Sec. 532.0255.	COMPLIANCE STANDARDS AND STANDARDIZED	
30		PROCESSES . . . . .	46
31	Sec. 532.0256.	RECIPIENT COMPLIANCE . . . . .	48
32	Sec. 532.0257.	HEALTH CARE PROVIDER COMPLIANCE . . . . .	48
33	Sec. 532.0258.	HEALTH CARE PROVIDER: USE OF	
34		PROPRIETARY SYSTEM . . . . .	50

1	Sec. 532.0259.	STAKEHOLDER INPUT . . . . .	51
2	Sec. 532.0260.	RULES . . . . .	52
3	SUBCHAPTER G. APPLICANTS AND RECIPIENTS		
4	Sec. 532.0301.	BILL OF RIGHTS AND BILL OF	
5		RESPONSIBILITIES . . . . .	52
6	Sec. 532.0302.	UNIFORM FAIR HEARING RULES . . . . .	54
7	Sec. 532.0303.	SUPPORT AND INFORMATION SERVICES FOR	
8		RECIPIENTS . . . . .	56
9	Sec. 532.0304.	NURSING SERVICES ASSESSMENTS . . . . .	61
10	Sec. 532.0305.	THERAPY SERVICES ASSESSMENTS . . . . .	64
11	Sec. 532.0306.	WELLNESS SCREENING PROGRAM . . . . .	65
12	Sec. 532.0307.	FEDERALLY QUALIFIED HEALTH CENTER AND	
13		RURAL HEALTH CLINIC SERVICES . . . . .	65
14	SUBCHAPTER H. PROGRAMS AND SERVICES FOR CERTAIN CATEGORIES OF		
15	MEDICAID POPULATION		
16	Sec. 532.0351.	TAILORED BENEFIT PACKAGES FOR CERTAIN	
17		CATEGORIES OF MEDICAID POPULATION . . . . .	67
18	Sec. 532.0352.	WAIVER PROGRAM FOR CERTAIN INDIVIDUALS	
19		WITH CHRONIC HEALTH CONDITIONS . . . . .	70
20	Sec. 532.0353.	BUY-IN PROGRAMS FOR CERTAIN INDIVIDUALS	
21		WITH DISABILITIES . . . . .	72
22	SUBCHAPTER I. UTILIZATION REVIEW, PRIOR AUTHORIZATION, AND		
23	COVERAGE PROCESSES AND DETERMINATIONS		
24	Sec. 532.0401.	REVIEW OF PRIOR AUTHORIZATION AND	
25		UTILIZATION REVIEW PROCESSES . . . . .	73
26	Sec. 532.0402.	ACCESSIBILITY OF INFORMATION REGARDING	
27		PRIOR AUTHORIZATION REQUIREMENTS . . . . .	74
28	Sec. 532.0403.	NOTICE REQUIREMENTS REGARDING COVERAGE	
29		OR PRIOR AUTHORIZATION DENIAL AND	
30		INCOMPLETE REQUESTS . . . . .	76
31	Sec. 532.0404.	EXTERNAL MEDICAL REVIEW . . . . .	78
32	SUBCHAPTER J. COST-SAVING INITIATIVES		
33	Sec. 532.0451.	HOSPITAL EMERGENCY ROOM USE REDUCTION	
34		INITIATIVES . . . . .	82

1 Sec. 532.0452. PHYSICIAN INCENTIVE PROGRAM TO REDUCE  
2 HOSPITAL EMERGENCY ROOM USE FOR  
3 NON-EMERGENT CONDITIONS . . . . . 85  
4 Sec. 532.0453. CONTINUED IMPLEMENTATION OF CERTAIN  
5 INTERVENTIONS AND BEST PRACTICES BY  
6 PROVIDERS; SEMIANNUAL REPORT . . . . . 86  
7 Sec. 532.0454. HEALTH SAVINGS ACCOUNT PILOT PROGRAM . . . . . 87  
8 Sec. 532.0455. DURABLE MEDICAL EQUIPMENT REUSE PROGRAM . . . . . 88

9 CHAPTER 532. MEDICAID ADMINISTRATION AND OPERATION IN GENERAL  
10 SUBCHAPTER A. GENERAL PROVISIONS

11 Revised Law

12 Sec. 532.0001. DEFINITION. In this chapter, "recipient"  
13 means a Medicaid recipient. (New.)

14 Revisor's Note

15 The definition of "recipient" is added to the  
16 revised law for drafting convenience and to eliminate  
17 the frequent, unnecessary repetition of the substance  
18 of the definition.

19 SUBCHAPTER B. ADMINISTRATION

20 Revised Law

21 Sec. 532.0051. COMMISSION ADMINISTRATION OF MEDICAID. (a)  
22 The commission is the state agency designated to administer federal  
23 Medicaid money.

24 (b) The commission shall:

25 (1) in each agency that operates a portion of  
26 Medicaid, plan and direct Medicaid, including the management of the  
27 Medicaid managed care system and the development, procurement,  
28 management, and monitoring of contracts necessary to implement that  
29 system; and

30 (2) establish requirements for and define the scope of  
31 the ongoing evaluation of the Medicaid managed care system  
32 conducted in conjunction with the Department of State Health  
33 Services under Section 108.0065, Health and Safety Code. (Gov.  
34 Code, Secs. 531.021(a), (b).)

1 Source Law

2 Sec. 531.021. ADMINISTRATION OF MEDICAID. (a)  
3 The commission is the state agency designated to  
4 administer federal Medicaid funds.

5 (b) The commission shall:

6 (1) plan and direct Medicaid in each  
7 agency that operates a portion of Medicaid, including  
8 the management of the Medicaid managed care system and  
9 the development, procurement, management, and  
10 monitoring of contracts necessary to implement the  
11 Medicaid managed care system; and

12 (2) establish requirements for and define  
13 the scope of the ongoing evaluation of the Medicaid  
14 managed care system conducted in conjunction with the  
15 Department of State Health Services under Section  
16 108.0065, Health and Safety Code.

17 Revisor's Note

18 Section 531.021(a), Government Code, refers to  
19 federal Medicaid "funds." Throughout this chapter, the  
20 revised law substitutes "money" for "funds" because,  
21 in context, the meaning is the same and "money" is the  
22 more commonly used term.

23 Revised Law

24 Sec. 532.0052. STREAMLINING ADMINISTRATIVE PROCESSES. The  
25 commission shall make every effort:

26 (1) using the commission's existing resources, to  
27 reduce the paperwork and other administrative burdens placed on  
28 recipients, Medicaid providers, and other Medicaid participants,  
29 and shall use technology and efficient business practices to reduce  
30 those burdens; and

31 (2) to improve the business practices associated with  
32 Medicaid administration by any method the commission determines is  
33 cost-effective, including:

34 (A) expanding electronic claims payment system  
35 use;

36 (B) developing an Internet portal system for  
37 prior authorization requests;

38 (C) encouraging Medicaid providers to submit  
39 program participation applications electronically;

40 (D) ensuring that the Medicaid provider  
41 application is easy to locate on the Internet so that providers can

1 conveniently apply to the program;

2 (E) working with federal partners to take  
3 advantage of every opportunity to maximize additional federal  
4 funding for technology in Medicaid; and

5 (F) encouraging providers' increased use of  
6 medical technology, including increasing providers' use of:

7 (i) electronic communications between  
8 patients and their physicians or other health care providers;

9 (ii) electronic prescribing tools that  
10 provide current payer formulary information at the time the  
11 physician or other health care provider writes a prescription and  
12 that support the electronic transmission of a prescription;

13 (iii) ambulatory computerized order entry  
14 systems that facilitate at the point of care physician and other  
15 health care provider orders for medications and laboratory and  
16 radiological tests;

17 (iv) inpatient computerized order entry  
18 systems to reduce errors, improve health care quality, and lower  
19 costs in a hospital setting;

20 (v) regional data-sharing to coordinate  
21 patient care across a community for patients who are treated by  
22 multiple providers; and

23 (vi) electronic intensive care unit  
24 technology to allow physicians to fully monitor hospital patients  
25 remotely. (Gov. Code, Sec. 531.02411.)

26 Source Law

27 Sec. 531.02411. STREAMLINING ADMINISTRATIVE  
28 PROCESSES. The commission shall make every effort  
29 using the commission's existing resources to reduce  
30 the paperwork and other administrative burdens placed  
31 on Medicaid recipients and providers and other  
32 participants in Medicaid and shall use technology and  
33 efficient business practices to decrease those  
34 burdens. In addition, the commission shall make every  
35 effort to improve the business practices associated  
36 with the administration of Medicaid by any method the  
37 commission determines is cost-effective, including:

38 (1) expanding the utilization of the  
39 electronic claims payment system;

40 (2) developing an Internet portal system  
41 for prior authorization requests;

1 (3) encouraging Medicaid providers to  
2 submit their program participation applications  
3 electronically;

4 (4) ensuring that the Medicaid provider  
5 application is easy to locate on the Internet so that  
6 providers may conveniently apply to the program;

7 (5) working with federal partners to take  
8 advantage of every opportunity to maximize additional  
9 federal funding for technology in Medicaid; and

10 (6) encouraging the increased use of  
11 medical technology by providers, including increasing  
12 their use of:

13 (A) electronic communications  
14 between patients and their physicians or other health  
15 care providers;

16 (B) electronic prescribing tools  
17 that provide up-to-date payer formulary information at  
18 the time a physician or other health care practitioner  
19 writes a prescription and that support the electronic  
20 transmission of a prescription;

21 (C) ambulatory computerized order  
22 entry systems that facilitate physician and other  
23 health care practitioner orders at the point of care  
24 for medications and laboratory and radiological tests;

25 (D) inpatient computerized order  
26 entry systems to reduce errors, improve health care  
27 quality, and lower costs in a hospital setting;

28 (E) regional data-sharing to  
29 coordinate patient care across a community for  
30 patients who are treated by multiple providers; and

31 (F) electronic intensive care unit  
32 technology to allow physicians to fully monitor  
33 hospital patients remotely.

34 Revisor's Note

35 Sections 531.02411(6)(B) and (C), Government  
36 Code, refer to a health care "practitioner," while  
37 other provisions of Section 531.02411 refer to a  
38 health care "provider." The revised law substitutes  
39 "provider" for "practitioner" for consistency of  
40 terminology and because the terms are synonymous and  
41 the former is more commonly used in Subtitle I, Title  
42 4, Government Code, which includes this chapter.

43 Revised Law

44 Sec. 532.0053. GRIEVANCES. (a) The commission shall:

45 (1) adopt a definition of "grievance" related to  
46 Medicaid and ensure the definition is consistent among divisions  
47 within the commission to ensure all grievances are managed  
48 consistently;

49 (2) standardize Medicaid grievance data reporting and  
50 tracking among divisions within the commission;

1 (3) implement a no-wrong-door system for Medicaid  
2 grievances reported to the commission; and

3 (4) verify grievance data a Medicaid managed care  
4 organization reports.

5 (b) The commission shall establish a procedure for  
6 expedited resolution of a grievance related to Medicaid that allows  
7 the commission to:

8 (1) identify a grievance related to a Medicaid  
9 access-to-care issue that is urgent and requires an expedited  
10 resolution; and

11 (2) resolve the grievance within a specified period.

12 (c) The commission shall:

13 (1) aggregate recipient and Medicaid provider  
14 grievance data to provide a comprehensive data set of grievances;  
15 and

16 (2) make the aggregated data available to the  
17 legislature and the public in a manner that does not allow for the  
18 identification of a particular recipient or provider. (Gov. Code,  
19 Sec. 531.02131.)

20 Source Law

21 Sec. 531.02131. GRIEVANCES RELATED TO MEDICAID.

22 (a) The commission shall adopt a definition of  
23 "grievance" related to Medicaid and ensure the  
24 definition is consistent among divisions within the  
25 commission to ensure all grievances are managed  
26 consistently.

27 (b) The commission shall standardize Medicaid  
28 grievance data reporting and tracking among divisions  
29 within the commission.

30 (c) The commission shall implement a  
31 no-wrong-door system for Medicaid grievances reported  
32 to the commission.

33 (d) The commission shall establish a procedure  
34 for expedited resolution of a grievance related to  
35 Medicaid that allows the commission to:

36 (1) identify a grievance related to a  
37 Medicaid access to care issue that is urgent and  
38 requires an expedited resolution; and

39 (2) resolve the grievance within a  
40 specified period.

41 (e) The commission shall verify grievance data  
42 reported by a Medicaid managed care organization.

43 (f) The commission shall:

44 (1) aggregate Medicaid recipient and  
45 provider grievance data to provide a comprehensive  
46 data set of grievances; and

47 (2) make the aggregated data available to

1 the legislature and the public in a manner that does  
2 not allow for the identification of a particular  
3 recipient or provider.

4 Revised Law

5 Sec. 532.0054. OFFICE OF COMMUNITY ACCESS AND SERVICES.

6 The executive commissioner shall establish within the commission an  
7 office of community access and services. The office is responsible  
8 for:

9 (1) collaborating with community, state, and federal  
10 stakeholders to improve the elements of the health care system that  
11 are involved in delivering Medicaid services; and

12 (2) sharing with Medicaid providers, including  
13 hospitals, any best practices, resources, or other information  
14 regarding improvements to the health care system. (Gov. Code, Sec.  
15 531.020.)

16 Source Law

17 Sec. 531.020. OFFICE OF COMMUNITY ACCESS AND  
18 SERVICES. The executive commissioner shall establish  
19 within the commission an office of community access  
20 and services. The office is responsible for:

21 (1) collaborating with community, state,  
22 and federal stakeholders to improve the elements of  
23 the health care system that are involved in the  
24 delivery of Medicaid services; and

25 (2) sharing with Medicaid providers,  
26 including hospitals, any best practices, resources, or  
27 other information regarding improvements to the health  
28 care system.

29 Revised Law

30 Sec. 532.0055. SERVICE DELIVERY AUDIT MECHANISMS. The

31 commission shall make every effort to ensure the integrity of  
32 Medicaid. To ensure that integrity, the commission shall:

33 (1) perform risk assessments of every element of the  
34 program and audit the program elements determined to present the  
35 greatest risks;

36 (2) ensure that sufficient oversight is in place for  
37 the Medicaid medical transportation program and that a quality  
38 review assessment of that program occurs; and

39 (3) evaluate Medicaid with respect to use of the  
40 metrics developed through the Texas Health Steps performance  
41 improvement plan to guide changes and improvements to the program.

1 (Gov. Code, Sec. 531.02412.)

2 Source Law

3 Sec. 531.02412. SERVICE DELIVERY AUDIT  
4 MECHANISMS. (a) The commission shall make every  
5 effort to ensure the integrity of Medicaid. To ensure  
6 that integrity, the commission shall:

7 (1) perform risk assessments of every  
8 element of the program and audit those elements of the  
9 program that are determined to present the greatest  
10 risks;

11 (2) ensure that sufficient oversight is in  
12 place for the Medicaid medical transportation program;

13 (3) ensure that a quality review  
14 assessment of the Medicaid medical transportation  
15 program occurs; and

16 (4) evaluate Medicaid with respect to use  
17 of the metrics developed through the Texas Health  
18 Steps performance improvement plan to guide changes  
19 and improvements to the program.

20 Revised Law

21 Sec. 532.0056. FEDERAL AUTHORIZATION FOR REFORM. The  
22 executive commissioner shall seek a waiver under Section 1115 of  
23 the Social Security Act (42 U.S.C. Section 1315) to the state  
24 Medicaid plan that is designed to achieve the following objectives  
25 regarding Medicaid and alternatives to Medicaid:

26 (1) provide flexibility to determine Medicaid  
27 eligibility categories and income levels;

28 (2) provide flexibility to design Medicaid benefits  
29 that meet the demographic, public health, clinical, and cultural  
30 needs of this state or regions within this state;

31 (3) encourage use of the private health benefits  
32 coverage market rather than public benefits systems;

33 (4) encourage individuals who have access to private  
34 employer-based health benefits to obtain or maintain those  
35 benefits;

36 (5) create a culture of shared financial  
37 responsibility, accountability, and participation in Medicaid by:

38 (A) establishing and enforcing copayment  
39 requirements similar to private sector principles for all  
40 eligibility groups;

41 (B) promoting the use of health savings accounts  
42 to influence a culture of individual responsibility; and

1 (C) promoting the use of vouchers for  
2 consumer-directed services in which consumers manage and pay for  
3 health-related services provided to them using program vouchers;

4 (6) consolidate federal funding streams, including  
5 money from the disproportionate share hospitals and upper payment  
6 limit supplemental payment programs and other federal Medicaid  
7 money, to ensure the most effective and efficient use of those  
8 funding streams;

9 (7) allow flexibility in the use of state money used to  
10 obtain federal matching money, including allowing the use of  
11 intergovernmental transfers, certified public expenditures, costs  
12 not otherwise matchable, or other money and funding mechanisms to  
13 obtain federal matching money;

14 (8) empower individuals who are uninsured to acquire  
15 health benefits coverage through the promotion of cost-effective  
16 coverage models that provide access to affordable primary,  
17 preventive, and other health care on a sliding scale, with fees paid  
18 at the point of service; and

19 (9) allow for the redesign of long-term care services  
20 and supports to increase access to patient-centered care in the  
21 most cost-effective manner. (Gov. Code, Sec. 537.002.)

22 Source Law

23 Sec. 537.002. FEDERAL AUTHORIZATION FOR  
24 MEDICAID REFORM. (a) The executive commissioner  
25 shall seek a waiver under Section 1115 of the federal  
26 Social Security Act (42 U.S.C. Section 1315) to the  
27 state Medicaid plan.

28 (b) The waiver under this section must be  
29 designed to achieve the following objectives regarding  
30 Medicaid and alternatives to Medicaid:

31 (1) provide flexibility to determine  
32 Medicaid eligibility categories and income levels;

33 (2) provide flexibility to design Medicaid  
34 benefits that meet the demographic, public health,  
35 clinical, and cultural needs of this state or regions  
36 within this state;

37 (3) encourage use of the private health  
38 benefits coverage market rather than public benefits  
39 systems;

40 (4) encourage people who have access to  
41 private employer-based health benefits to obtain or  
42 maintain those benefits;

43 (5) create a culture of shared financial  
44 responsibility, accountability, and participation in  
45 Medicaid by:

1 (A) establishing and enforcing  
2 copayment requirements similar to private sector  
3 principles for all eligibility groups;

4 (B) promoting the use of health  
5 savings accounts to influence a culture of individual  
6 responsibility; and

7 (C) promoting the use of vouchers for  
8 consumer-directed services in which consumers manage  
9 and pay for health-related services provided to them  
10 using program vouchers;

11 (6) consolidate federal funding streams,  
12 including funds from the disproportionate share  
13 hospitals and upper payment limit supplemental payment  
14 programs and other federal Medicaid funds, to ensure  
15 the most effective and efficient use of those funding  
16 streams;

17 (7) allow flexibility in the use of state  
18 funds used to obtain federal matching funds, including  
19 allowing the use of intergovernmental transfers,  
20 certified public expenditures, costs not otherwise  
21 matchable, or other funds and funding mechanisms to  
22 obtain federal matching funds;

23 (8) empower individuals who are uninsured  
24 to acquire health benefits coverage through the  
25 promotion of cost-effective coverage models that  
26 provide access to affordable primary, preventive, and  
27 other health care on a sliding scale, with fees paid at  
28 the point of service; and

29 (9) allow for the redesign of long-term  
30 care services and supports to increase access to  
31 patient-centered care in the most cost-effective  
32 manner.

33 Revisor's Note

34 Section 537.002(b)(4), Government Code, refers  
35 to "people" who have access to private employer-based  
36 health benefits. Throughout this chapter, the revised  
37 law substitutes "individuals" or "individual" for  
38 "people" or "person," respectively, for clarity and  
39 consistency where the context makes clear that the  
40 referenced person is an individual and not an entity  
41 described by the definition of "person" provided by  
42 Section 311.005, Government Code (Code Construction  
43 Act), applicable to this code.

44 Revised Law

45 Sec. 532.0057. FEES, CHARGES, AND RATES. (a) The executive  
46 commissioner shall adopt reasonable rules and standards governing  
47 the determination of fees, charges, and rates for Medicaid  
48 payments.

49 (b) In adopting rules and standards required by Subsection  
50 (a), the executive commissioner:

1 (1) may provide for payment of fees, charges, and  
2 rates in accordance with:

3 (A) formulas, procedures, or methodologies  
4 commission rules prescribe;

5 (B) state or federal law, policies, rules,  
6 regulations, or guidelines;

7 (C) economic conditions that substantially and  
8 materially affect provider participation in Medicaid, as the  
9 executive commissioner determines; or

10 (D) available levels of appropriated state and  
11 federal money; and

12 (2) shall include financial performance standards  
13 that, in the event of a proposed rate reduction, provide private  
14 ICF-IID facilities and home and community-based services providers  
15 with flexibility in determining how to use Medicaid payments to  
16 provide services in the most cost-effective manner while continuing  
17 to meet state and federal Medicaid requirements.

18 (c) Notwithstanding any other provision of Chapter 32,  
19 Human Resources Code, Chapter 531 or revised provisions of Chapter  
20 531, as that chapter existed on March 31, 2025, or \_\_\_\_\_  
21 [[[Chapter 533]]], the commission may adjust the fees, charges, and  
22 rates paid to Medicaid providers as necessary to achieve the  
23 objectives of Medicaid in a manner consistent with the  
24 considerations described by Subsection (b)(1).

25 (d) In adopting rates for Medicaid payments under  
26 Subsection (a), the executive commissioner may adopt reimbursement  
27 rates for appropriate nursing services provided to recipients with  
28 certain health conditions if those services are determined to  
29 provide a cost-effective alternative to hospitalization. A  
30 physician must certify that the nursing services are medically  
31 appropriate for the recipient for those services to qualify for  
32 reimbursement under this subsection.

33 (e) In adopting rates for Medicaid payments under  
34 Subsection (a), the executive commissioner may adopt

1 cost-effective reimbursement rates for group appointments with  
2 Medicaid providers for certain diseases and medical conditions  
3 commission rules specify. (Gov. Code, Secs. 531.021(b-1), (c), (d),  
4 (e), (f), (g).)

5 Source Law

6 (b-1) The executive commissioner shall adopt  
7 reasonable rules and standards governing the  
8 determination of fees, charges, and rates for Medicaid  
9 payments.

10 (c) The executive commissioner in the adoption  
11 of reasonable rules and standards under Subsection  
12 (b-1) shall include financial performance standards  
13 that, in the event of a proposed rate reduction,  
14 provide private ICF-IID facilities and home and  
15 community-based services providers with flexibility  
16 in determining how to use Medicaid payments to provide  
17 services in the most cost-effective manner while  
18 continuing to meet the state and federal requirements  
19 of Medicaid.

20 (d) In adopting rules and standards required by  
21 Subsection (b-1), the executive commissioner may  
22 provide for payment of fees, charges, and rates in  
23 accordance with:

24 (1) formulas, procedures, or  
25 methodologies prescribed by the commission's rules;

26 (2) applicable state or federal law,  
27 policies, rules, regulations, or guidelines;

28 (3) economic conditions that  
29 substantially and materially affect provider  
30 participation in Medicaid, as determined by the  
31 executive commissioner; or

32 (4) available levels of appropriated state  
33 and federal funds.

34 (e) Notwithstanding any other provision of  
35 Chapter 32, Human Resources Code, Chapter 533, or this  
36 chapter, the commission may adjust the fees, charges,  
37 and rates paid to Medicaid providers as necessary to  
38 achieve the objectives of Medicaid in a manner  
39 consistent with the considerations described by  
40 Subsection (d).

41 (f) In adopting rates for Medicaid payments  
42 under Subsection (b-1), the executive commissioner may  
43 adopt reimbursement rates for appropriate nursing  
44 services provided to recipients with certain health  
45 conditions if those services are determined to provide  
46 a cost-effective alternative to hospitalization. A  
47 physician must certify that the nursing services are  
48 medically appropriate for the recipient for those  
49 services to qualify for reimbursement under this  
50 subsection.

51 (g) In adopting rates for Medicaid payments  
52 under Subsection (b-1), the executive commissioner may  
53 adopt cost-effective reimbursement rates for group  
54 appointments with Medicaid providers for certain  
55 diseases and medical conditions specified by rules of  
56 the executive commissioner.

57 Revisor's Note

58 Section 531.021(g), Government Code, refers to  
59 "rules of the executive commissioner." The revised law

1 substitutes "commission rules" for the quoted language  
2 for clarity and consistency in the terminology used  
3 within Subtitle I, Title 4, Government Code, which  
4 includes this chapter, and because under Section  
5 531.033, Government Code, revised as Section \_\_\_\_\_,  
6 the executive commissioner of the Health and Human  
7 Services Commission adopts rules for the commission.

8 Revised Law

9 Sec. 532.0058. ACUTE CARE BILLING COORDINATION SYSTEM;  
10 PENALTIES. (a) The acute care Medicaid billing coordination  
11 system for the fee-for-service and primary care case management  
12 delivery models for which the commission contracts must, on entry  
13 of a claim in the claims system:

14 (1) identify within 24 hours whether another entity  
15 has primary responsibility for paying the claim; and

16 (2) submit the claim to the entity the system  
17 determines is the primary payor.

18 (b) The billing coordination system may not increase  
19 Medicaid claims payment error rates.

20 (c) If cost-effective and feasible, the commission shall  
21 contract to expand the acute care Medicaid billing coordination  
22 system to process claims for all other Medicaid health care  
23 services in the manner the system processes claims for acute care  
24 services. This subsection does not apply to claims for Medicaid  
25 health care services if, before September 1, 2009, those claims  
26 were being processed by an alternative billing coordination system.

27 (d) If cost-effective, the executive commissioner shall  
28 adopt rules to enable the acute care Medicaid billing coordination  
29 system to identify an entity with primary responsibility for paying  
30 a claim that is processed by the system and establish reporting  
31 requirements for an entity that may have a contractual  
32 responsibility to pay for the types of services that are provided  
33 under Medicaid and the claims for which are processed by the system.

34 (e) An entity that holds a permit, license, or certificate

1 of authority issued by a regulatory agency of this state:

2 (1) must allow a contractor under this section access  
3 to databases to allow the contractor to carry out the purposes of  
4 this section, subject to the contractor's contract with the  
5 commission and rules the executive commissioner adopts under this  
6 section; and

7 (2) is subject to an administrative penalty or other  
8 sanction as provided by the law applicable to the permit, license,  
9 or certificate of authority for the entity's violation of a rule the  
10 executive commissioner adopts under this section.

11 (f) Public money may not be spent on an entity that is not in  
12 compliance with this section unless the executive commissioner and  
13 the entity enter into a memorandum of understanding.

14 (g) Information obtained under this section is  
15 confidential. The contractor may use the information only for the  
16 purposes authorized under this section. A person commits an  
17 offense if the person knowingly uses information obtained under  
18 this section for any purpose not authorized under this section. An  
19 offense under this subsection is a Class B misdemeanor and all other  
20 penalties may apply. (Gov. Code, Secs. 531.02413(a) (part), (a-1),  
21 (b), (c), (d), (e).)

22 Source Law

23 Sec. 531.02413. BILLING COORDINATION SYSTEM.

24 (a) [If cost-effective and feasible, the commission  
25 shall, on or before March 1, 2008, contract through an  
26 existing procurement process for the implementation  
27 of] an acute care Medicaid billing coordination system  
28 for the fee-for-service and primary care case  
29 management delivery models that will, upon entry in  
30 the claims system, identify within 24 hours whether  
31 another entity has primary responsibility for paying  
32 the claim and submit the claim to the entity the system  
33 determines is the primary payor. The system may not  
34 increase Medicaid claims payment error rates.

35 (a-1) If cost-effective and feasible, the  
36 commission shall contract to expand the Medicaid  
37 billing coordination system described by Subsection  
38 (a) to process claims for all other health care  
39 services provided through Medicaid in the manner  
40 claims for acute care services are processed by the  
41 system under Subsection (a). This subsection does not  
42 apply to claims for health care services provided  
43 through Medicaid if, before September 1, 2009, those  
44 claims were being processed by an alternative billing  
45 coordination system.

1 (b) If cost-effective, the executive  
2 commissioner shall adopt rules for the purpose of  
3 enabling the system described by Subsection (a) to  
4 identify an entity with primary responsibility for  
5 paying a claim that is processed by the system under  
6 Subsection (a) and establish reporting requirements  
7 for any entity that may have a contractual  
8 responsibility to pay for the types of services that  
9 are provided under Medicaid and the claims for which  
10 are processed by the system under Subsection (a).

11 (c) An entity that holds a permit, license, or  
12 certificate of authority issued by a regulatory agency  
13 of the state must allow a contractor under this section  
14 access to databases to allow the contractor to carry  
15 out the purposes of this section, subject to the  
16 contractor's contract with the commission and rules  
17 adopted under this section, and is subject to an  
18 administrative penalty or other sanction as provided  
19 by the law applicable to the permit, license, or  
20 certificate of authority for a violation by the entity  
21 of a rule adopted under this section.

22 (d) After September 1, 2008, no public funds  
23 shall be expended on entities not in compliance with  
24 this section unless a memorandum of understanding is  
25 entered into between the entity and the executive  
26 commissioner.

27 (e) Information obtained under this section is  
28 confidential. The contractor may use the information  
29 only for the purposes authorized under this section. A  
30 person commits an offense if the person knowingly uses  
31 information obtained under this section for any  
32 purpose not authorized under this section. An offense  
33 under this subsection is a Class B misdemeanor and all  
34 other penalties may apply.

35 Revisor's Note

36 (1) Section 531.02413(a), Government Code,  
37 requires the Health and Human Services Commission to  
38 contract for the implementation of an acute care  
39 Medicaid billing coordination system on or before  
40 March 1, 2008, if cost-effective and feasible.  
41 Because the commission has implemented the described  
42 system, the revised law omits this provision as  
43 executed. The omitted law reads:

44 (a) If cost-effective and feasible,  
45 the commission shall, on or before March 1,  
46 2008, contract through an existing  
47 procurement process for the implementation  
48 of [an acute care Medicaid billing  
49 coordination system] . . . .

50 (2) Section 531.02413(d), Government Code,  
51 restricts certain spending of public money "[a]fter  
52 September 1, 2008." The revised law omits the quoted  
53 language as unnecessary because the specified date has

1 passed, and any future expenditure of public money  
2 would necessarily occur after that date.

3 Revised Law

4 Sec. 532.0059. RECOVERY OF CERTAIN THIRD-PARTY  
5 REIMBURSEMENTS. The commission shall obtain Medicaid  
6 reimbursement from each fiscal intermediary who makes a payment to  
7 a service provider on behalf of the Medicare program, including a  
8 reimbursement for a payment made to a home health services provider  
9 or nursing facility for services provided to an individual who is  
10 eligible to receive health care benefits under both Medicaid and  
11 the Medicare program. (Gov. Code, Sec. 531.0392.)

12 Source Law

13 Sec. 531.0392. RECOVERY OF CERTAIN THIRD-PARTY  
14 REIMBURSEMENTS UNDER MEDICAID. (a) In this section,  
15 "dually eligible individual" means an individual who  
16 is eligible to receive health care benefits under both  
17 Medicaid and the Medicare program.

18 (b) The commission shall obtain Medicaid  
19 reimbursement from each fiscal intermediary who makes  
20 a payment to a service provider on behalf of the  
21 Medicare program, including a reimbursement for a  
22 payment made to a home health services provider or  
23 nursing facility for services rendered to a dually  
24 eligible individual.

25 Revised Law

26 Sec. 532.0060. DENTAL DIRECTOR. The executive commissioner  
27 shall appoint a Medicaid dental director who is a licensed dentist  
28 under Subtitle D, Title 3, Occupations Code, and rules the State  
29 Board of Dental Examiners adopts under that subtitle. (Gov. Code,  
30 Sec. 531.02114.)

31 Source Law

32 Sec. 531.02114. DENTAL DIRECTOR. The executive  
33 commissioner shall appoint for Medicaid a dental  
34 director who is a licensed dentist under Subtitle D,  
35 Title 3, Occupations Code, and rules adopted under  
36 that subtitle by the State Board of Dental Examiners.

37 Revised Law

38 Sec. 532.0061. ALIGNMENT OF MEDICAID AND MEDICARE DIABETIC  
39 EQUIPMENT AND SUPPLIES WRITTEN ORDER PROCEDURES. (a) The  
40 commission shall review Medicaid forms and requirements regarding  
41 written orders for diabetic equipment and supplies to identify

1 variations between permissible Medicaid ordering procedures and  
2 ordering procedures available to Medicare providers.

3 (b) To the extent practicable and in conformity with Chapter  
4 157, Occupations Code, and Chapter 483, Health and Safety Code,  
5 after the commission conducts a review under Subsection (a), the  
6 commission or executive commissioner, as appropriate, shall modify  
7 only Medicaid forms, rules, and procedures applicable to orders for  
8 diabetic equipment and supplies to provide for an ordering system  
9 that is comparable to the Medicare ordering system for diabetic  
10 equipment and supplies. The ordering system must permit a diabetic  
11 equipment or supplies supplier to complete forms by hand or enter  
12 medical information or supply orders electronically into a form as  
13 necessary to provide the information required to dispense diabetic  
14 equipment or supplies.

15 (c) A diabetic equipment and supplies provider may bill and  
16 collect payment for the provider's services if the provider has a  
17 copy of the form that meets the requirements of Subsection (b) and  
18 is signed by a medical provider licensed in this state to treat  
19 diabetic patients. Additional documentation may not be required.  
20 (Gov. Code, Sec. 531.099.)

21 Source Law

22 Sec. 531.099. ALIGNMENT OF MEDICAID DIABETIC  
23 EQUIPMENT AND SUPPLIES WRITTEN ORDER PROCEDURES WITH  
24 MEDICARE DIABETIC EQUIPMENT AND SUPPLIES WRITTEN ORDER  
25 PROCEDURES. (a) The commission shall review forms and  
26 requirements under Medicaid regarding written orders  
27 for diabetic equipment and supplies to identify  
28 variations between permissible ordering procedures  
29 under that program and ordering procedures available  
30 to providers under the Medicare program.

31 (b) To the extent practicable, and in conformity  
32 with Chapter 157, Occupations Code, and Chapter 483,  
33 Health and Safety Code, after conducting a review  
34 under Subsection (a) the commission or executive  
35 commissioner, as appropriate, shall modify only forms,  
36 rules, and procedures applicable to orders for  
37 diabetic equipment and supplies under Medicaid to  
38 provide for an ordering system that is comparable to  
39 the ordering system for diabetic equipment and  
40 supplies under the Medicare program. The ordering  
41 system must permit a diabetic equipment or supplies  
42 supplier to complete the forms by hand or to enter by  
43 electronic format medical information or supply orders  
44 into any form as necessary to provide the information  
45 required to dispense diabetic equipment or supplies.

46 (c) A provider of diabetic equipment and

1 supplies may bill and collect payment for the  
2 provider's services if the provider has a copy of the  
3 form that meets the requirements of Subsection (b) and  
4 that is signed by a medical practitioner licensed in  
5 this state to treat diabetic patients. Additional  
6 documentation may not be required.

7 Revisor's Note

8 Section 531.099(c), Government Code, refers to a  
9 "medical practitioner." The revised law substitutes  
10 "provider" for "practitioner" for the reason stated in  
11 the revisor's note to Section 532.0052 of this chapter.

12 SUBCHAPTER C. FINANCING

13 Revised Law

14 Sec. 532.0101. FINANCING OPTIMIZATION. The commission  
15 shall ensure that the Medicaid finance system is optimized to:

- 16 (1) maximize this state's receipt of federal money;  
17 (2) create incentives for providers to use preventive  
18 care;  
19 (3) increase and retain providers in the system to  
20 maintain an adequate provider network;  
21 (4) more accurately reflect the costs borne by  
22 providers; and  
23 (5) encourage improvement of the quality of care.

24 (Gov. Code, Sec. 531.02113.)

25 Source Law

26 Sec. 531.02113. OPTIMIZATION OF MEDICAID  
27 FINANCING. The commission shall ensure that the  
28 Medicaid finance system is optimized to:

- 29 (1) maximize the state's receipt of  
30 federal funds;  
31 (2) create incentives for providers to use  
32 preventive care;  
33 (3) increase and retain providers in the  
34 system to maintain an adequate provider network;  
35 (4) more accurately reflect the costs  
36 borne by providers; and  
37 (5) encourage the improvement of the  
38 quality of care.

39 Revised Law

40 Sec. 532.0102. RETENTION OF CERTAIN MONEY TO ADMINISTER  
41 CERTAIN PROGRAMS; ANNUAL REPORT REQUIRED. (a) In this section,  
42 "directed payment program" means a delivery system and provider  
43 patient initiative implemented by this state under 42 C.F.R.

1 Section 438.6(c).

2 (b) This section applies only to money the commission  
3 receives from a source other than the general revenue fund to  
4 operate a waiver program established under Section 1115 of the  
5 Social Security Act (42 U.S.C. Section 1315) or a directed payment  
6 program or successor program as the commission determines.

7 (c) Subject to Subsection (d), the commission may retain  
8 from money to which this section applies an amount equal to the  
9 estimated costs necessary to administer the program for which the  
10 commission receives the money, but not to exceed \$8 million for a  
11 state fiscal year.

12 (d) If the commission determines that the commission needs  
13 additional money to administer a program described by Subsection  
14 (b), the commission may retain an additional amount with the  
15 governor's and the Legislative Budget Board's approval, but not to  
16 exceed a total retained amount equal to 0.25 percent of the total  
17 estimated amount the commission receives for the program.

18 (e) The commission shall spend the retained money to assist  
19 in paying the costs necessary to administer the program for which  
20 the commission receives the money, except that the commission may  
21 not use the money to pay any type of administrative cost that,  
22 before June 1, 2019, was funded with general revenue.

23 (f) The commission shall submit an annual report to the  
24 governor and the Legislative Budget Board that:

25 (1) details the amount of money the commission  
26 retained and spent under this section during the preceding state  
27 fiscal year, including a separate detail of any increase in the  
28 amount of money the commission retained for a program under  
29 Subsection (d);

30 (2) contains a transparent description of how the  
31 commission used the money described by Subdivision (1); and

32 (3) assesses the extent to which the retained money  
33 covered the estimated costs to administer the applicable program  
34 and states whether, based on that assessment, the commission

1 adjusted or considered adjustments to the amount retained.

2 (g) The executive commissioner shall adopt rules necessary  
3 to implement this section. (Gov. Code, Sec. 531.021135.)

4 Source Law

5 Sec. 531.021135. COMMISSION'S AUTHORITY TO  
6 RETAIN CERTAIN MONEY TO ADMINISTER CERTAIN MEDICAID  
7 PROGRAMS; REPORT REQUIRED. (a) In this section,  
8 "directed payment program" means a delivery system and  
9 provider patient initiative implemented by this state  
10 under 42 C.F.R. Section 438.6(c).

11 (b) This section applies only to money the  
12 commission receives from a source other than the  
13 general revenue fund to operate a waiver program  
14 established under Section 1115 of the federal Social  
15 Security Act (42 U.S.C. Section 1315) or a directed  
16 payment program or successor program as determined by  
17 the commission.

18 (c) Subject to Subsection (e), the commission  
19 may retain from money to which this section applies an  
20 amount equal to the estimated costs necessary to  
21 administer the program for which the money is  
22 received, but not to exceed \$8 million for a state  
23 fiscal year.

24 (d) The commission shall spend money retained  
25 under this section to assist in paying the costs  
26 necessary to administer the program for which the  
27 money is received, except that the commission may not  
28 use the money to pay any type of administrative cost  
29 that, before June 1, 2019, was funded with general  
30 revenue.

31 (e) If the commission determines that the  
32 commission needs additional money to administer a  
33 program described by Subsection (b), the commission  
34 may retain an additional amount with the approval of  
35 the governor and the Legislative Budget Board, but not  
36 to exceed a total retained amount equal to 0.25 percent  
37 of the total amount estimated to be received for the  
38 program.

39 (f) The commission shall submit an annual report  
40 to the governor and the Legislative Budget Board that:

41 (1) details the amount of money retained  
42 and spent by the commission under this section during  
43 the preceding state fiscal year, including a separate  
44 detail of any increase in the amount of money retained  
45 for a program under Subsection (e);

46 (2) contains a transparent description of  
47 how the commission used the money described by  
48 Subdivision (1); and

49 (3) assesses the extent to which the money  
50 retained by the commission under this section covered  
51 the estimated costs to administer the applicable  
52 program and states whether, based on that assessment,  
53 the commission adjusted or considered adjustments to  
54 the amount retained.

55 (g) The executive commissioner shall adopt  
56 rules necessary to implement this section.

57 Revised Law

58 Sec. 532.0103. BIENNIAL FINANCIAL REPORT. (a) The  
59 commission shall prepare a biennial Medicaid financial report

1 covering each state agency that operates a part of Medicaid and each  
2 component of Medicaid those agencies operate.

3 (b) The report must include:

4 (1) for each state agency that operates a part of  
5 Medicaid:

6 (A) a description of each of the Medicaid  
7 components the agency operates; and

8 (B) an accounting of all money related to  
9 Medicaid the agency received and disbursed during the period the  
10 report covers, including:

11 (i) the amount of any federal Medicaid  
12 money allocated to the agency for the support of each of the  
13 Medicaid components the agency operates;

14 (ii) the amount of any money the  
15 legislature appropriated to the agency for each of those  
16 components; and

17 (iii) the amount of Medicaid payments and  
18 related expenditures made by or in connection with each of those  
19 components; and

20 (2) for each Medicaid component identified in the  
21 report:

22 (A) the amount and source of money or other  
23 revenue received by or made available to the agency for the  
24 component;

25 (B) the amount spent on each type of service or  
26 benefit provided by or under the component;

27 (C) the amount spent on component operations,  
28 including eligibility determination, claims processing, and case  
29 management; and

30 (D) the amount spent on any other administrative  
31 costs.

32 (c) The report must cover the three-year period ending on  
33 the last day of the previous fiscal year.

34 (d) The commission may request from any appropriate state

1 agency information necessary to complete the report. Each agency  
2 shall cooperate with the commission in providing information for  
3 the report.

4 (e) Not later than December 1 of each even-numbered year,  
5 the commission shall submit the report to the governor, the  
6 lieutenant governor, the speaker of the house of representatives,  
7 the presiding officer of each standing committee of the senate and  
8 house of representatives having jurisdiction over health and human  
9 services issues, and the state auditor. (Gov. Code, Sec.  
10 531.02111.)

11 Source Law

12 Sec. 531.02111. BIENNIAL MEDICAID FINANCIAL  
13 REPORT. (a) The commission shall prepare a biennial  
14 Medicaid financial report covering each state agency  
15 that operates any part of Medicaid and each component  
16 of Medicaid operated by those agencies.

17 (b) The report must include:

18 (1) for each state agency described by  
19 Subsection (a):

20 (A) a description of each of the  
21 components of Medicaid operated by the agency; and

22 (B) an accounting of all funds  
23 related to Medicaid received and disbursed by the  
24 agency during the period covered by the report,  
25 including:

26 (i) the amount of any federal  
27 Medicaid funds allocated to the agency for the support  
28 of each of the Medicaid components operated by the  
29 agency;

30 (ii) the amount of any funds  
31 appropriated by the legislature to the agency for each  
32 of those components; and

33 (iii) the amount of Medicaid  
34 payments and related expenditures made by or in  
35 connection with each of those components; and

36 (2) for each Medicaid component identified  
37 in the report:

38 (A) the amount and source of funds or  
39 other revenue received by or made available to the  
40 agency for the component;

41 (B) the amount spent on each type of  
42 service or benefit provided by or under the component;

43 (C) the amount spent on component  
44 operations, including eligibility determination,  
45 claims processing, and case management; and

46 (D) the amount spent on any other  
47 administrative costs.

48 (c) The report must cover the three-year period  
49 ending on the last day of the previous fiscal year.

50 (d) The commission may request from any  
51 appropriate state agency information necessary to  
52 complete the report. Each agency shall cooperate with  
53 the commission in providing information for the  
54 report.

55 (e) Not later than December 1 of each  
56 even-numbered year, the commission shall submit the

1 report to the governor, the lieutenant governor, the  
2 speaker of the house of representatives, the presiding  
3 officer of each standing committee of the senate and  
4 house of representatives having jurisdiction over  
5 health and human services issues, and the state  
6 auditor.

7 SUBCHAPTER D. PROVIDERS

8 Revised Law

9 Sec. 532.0151. STREAMLINING PROVIDER ENROLLMENT AND  
10 CREDENTIALING PROCESSES. (a) The commission shall streamline  
11 Medicaid provider enrollment and credentialing processes.

12 (b) In streamlining the Medicaid provider enrollment  
13 process, the commission shall establish a centralized Internet  
14 portal through which providers may enroll in Medicaid.

15 (c) In streamlining the Medicaid provider credentialing  
16 process, the commission may:

17 (1) designate a centralized credentialing entity;

18 (2) share information in the database established  
19 under Subchapter C, Chapter 32, Human Resources Code, with the  
20 centralized credentialing entity; and

21 (3) require all Medicaid managed care organizations to  
22 use the centralized credentialing entity as a hub for collecting  
23 and sharing information.

24 (d) The commission may:

25 (1) use the Internet portal created under Subsection  
26 (b) to create a single, consolidated Medicaid provider enrollment  
27 and credentialing process; and

28 (2) if cost-effective, contract with a third party to  
29 develop the single, consolidated process. (Gov. Code, Sec.  
30 531.02118.)

31 Source Law

32 Sec. 531.02118. STREAMLINING MEDICAID PROVIDER  
33 ENROLLMENT AND CREDENTIALING PROCESSES. (a) The  
34 commission shall streamline provider enrollment and  
35 credentialing processes under Medicaid.

36 (b) In streamlining the Medicaid provider  
37 enrollment process, the commission shall establish a  
38 centralized Internet portal through which providers  
39 may enroll in Medicaid. The commission may use the  
40 Internet portal created under this subsection to  
41 create a single, consolidated Medicaid provider  
42 enrollment and credentialing process.

1 (c) In streamlining the Medicaid provider  
2 credentialing process under this section, the  
3 commission may designate a centralized credentialing  
4 entity and may:

5 (1) share information in the database  
6 established under Subchapter C, Chapter 32, Human  
7 Resources Code, with the centralized credentialing  
8 entity; and

9 (2) require all managed care organizations  
10 contracting with the commission to provide health care  
11 services to Medicaid recipients under a managed care  
12 plan issued by the organization to use the centralized  
13 credentialing entity as a hub for the collection and  
14 sharing of information.

15 (d) If cost-effective, the commission may  
16 contract with a third party to develop the single,  
17 consolidated Medicaid provider enrollment and  
18 credentialing process authorized under Subsection  
19 (b).

20 Revisor's Note

21 Section 531.02118(c)(2), Government Code, refers  
22 to "managed care organizations contracting with the  
23 commission to provide health care services to Medicaid  
24 recipients under a managed care plan issued by the  
25 organization." Section 531.001(4-c), Government  
26 Code, which is revised in this subtitle as Section  
27 \_\_\_\_\_, defines "Medicaid managed care organization" as  
28 "a managed care organization as defined by Section  
29 533.001 that contracts with the commission under  
30 Chapter 533 to provide health care services to  
31 Medicaid recipients." That definition applies  
32 throughout the subtitle and is synonymous with the  
33 quoted phrase. The revised law therefore substitutes  
34 the defined term "Medicaid managed care organization"  
35 for the quoted phrase from Section 531.02118(c)(2).  
36 Furthermore, for consistency of terminology  
37 throughout this chapter, the revised law substitutes  
38 "Medicaid managed care organization" for  
39 substantively synonymous source law references to  
40 "managed care organization that contracts with the  
41 commission under Chapter 533," "managed care  
42 organization participating in Medicaid," "managed  
43 care organization under Chapter 533," "managed care

1 organization that contracts with the commission to  
2 provide health care services to Medicaid recipients,"  
3 and other similar references to managed care  
4 organizations.

5 Revised Law

6 Sec. 532.0152. USE OF NATIONAL PROVIDER IDENTIFIER NUMBER.

7 (a) In this section, "national provider identifier number" means  
8 the national provider identifier number required under Section  
9 1128J(e) of the Social Security Act (42 U.S.C. Section  
10 1320a-7k(e)).

11 (b) The commission shall transition from using a  
12 state-issued provider identifier number to using only a national  
13 provider identifier number in accordance with this section.

14 (c) The commission shall implement a Medicaid provider  
15 management and enrollment system and, following that  
16 implementation, use only a national provider identifier number to  
17 enroll a provider in Medicaid.

18 (d) The commission shall implement a modernized claims  
19 processing system and, following that implementation, use only a  
20 national provider identifier number to process claims for and  
21 authorize Medicaid services. (Gov. Code, Sec. 531.021182.)

22 Source Law

23 Sec. 531.021182. USE OF NATIONAL PROVIDER  
24 IDENTIFIER NUMBER. (a) In this section, "national  
25 provider identifier number" means the national  
26 provider identifier number required under Section  
27 1128J(e), Social Security Act (42 U.S.C. Section  
28 1320a-7k(e)).

29 (b) The commission shall transition from using a  
30 state-issued provider identifier number to using only  
31 a national provider identifier number in accordance  
32 with this section.

33 (c) The commission shall implement a Medicaid  
34 provider management and enrollment system and,  
35 following that implementation, use only a national  
36 provider identifier number to enroll a provider in  
37 Medicaid.

38 (d) The commission shall implement a modernized  
39 claims processing system and, following that  
40 implementation, use only a national provider  
41 identifier number to process claims for and authorize  
42 Medicaid services.

1 Revised Law

2 Sec. 532.0153. ENROLLMENT OF CERTAIN EYE HEALTH CARE  
3 PROVIDERS. (a) This section applies only to:

4 (1) an optometrist who is licensed by the Texas  
5 Optometry Board;

6 (2) a therapeutic optometrist who is licensed by the  
7 Texas Optometry Board;

8 (3) an ophthalmologist who is licensed by the Texas  
9 Medical Board; and

10 (4) an institution of higher education that provides  
11 an accredited program for:

12 (A) training as a doctor of optometry or an  
13 optometrist residency; or

14 (B) training as an ophthalmologist or an  
15 ophthalmologist residency.

16 (b) The commission may not prevent a provider to whom this  
17 section applies from enrolling as a Medicaid provider if the  
18 provider:

19 (1) either:

20 (A) joins an established practice of a health  
21 care provider or provider group that has a contract with a Medicaid  
22 managed care organization to provide health care services to  
23 recipients under Chapter \_\_\_\_\_ [[[Chapter 533]]]; or

24 (B) is employed by or otherwise compensated for  
25 providing training at an institution of higher education described  
26 by Subsection (a)(4);

27 (2) applies to be an enrolled Medicaid provider;

28 (3) if applicable, complies with the requirements of  
29 the contract described by Subdivision (1)(A); and

30 (4) complies with all other applicable requirements  
31 related to being a Medicaid provider.

32 (c) The commission may not prevent an institution of higher  
33 education from enrolling as a Medicaid provider if the institution:

34 (1) has a contract with a Medicaid managed care

1 organization to provide health care services to recipients under  
2 Chapter \_\_\_\_\_ [[[Chapter 533]]];

3 (2) applies to be an enrolled Medicaid provider;

4 (3) complies with the requirements of the contract  
5 described by Subdivision (1); and

6 (4) complies with all other applicable requirements  
7 related to being a Medicaid provider. (Gov. Code, Sec. 531.021191.)

8 Source Law

9 Sec. 531.021191. MEDICAID ENROLLMENT OF CERTAIN  
10 EYE HEALTH CARE PROVIDERS. (a) This section applies  
11 only to:

12 (1) an optometrist who is licensed by the  
13 Texas Optometry Board;

14 (2) a therapeutic optometrist who is  
15 licensed by the Texas Optometry Board;

16 (3) an ophthalmologist who is licensed by  
17 the Texas Medical Board; and

18 (4) an institution of higher education  
19 that provides an accredited program for:

20 (A) training as a Doctor of Optometry  
21 or an optometrist residency; or

22 (B) training as an ophthalmologist or  
23 an ophthalmologist residency.

24 (b) The commission may not prevent a provider to  
25 whom this section applies from enrolling as a Medicaid  
26 provider if the provider:

27 (1) either:

28 (A) joins an established practice of  
29 a health care provider or provider group that has a  
30 contract with a managed care organization to provide  
31 health care services to recipients under Chapter 533;  
32 or

33 (B) is employed by or otherwise  
34 compensated for providing training at an institution  
35 of higher education described by Subsection (a)(4);

36 (2) applies to be an enrolled provider  
37 under Medicaid;

38 (3) if applicable, complies with the  
39 requirements of the contract between the provider or  
40 the provider's group and the applicable managed care  
41 organization; and

42 (4) complies with all other applicable  
43 requirements related to being a Medicaid provider.

44 (c) The commission may not prevent an  
45 institution of higher education from enrolling as a  
46 Medicaid provider if the institution:

47 (1) has a contract with a managed care  
48 organization to provide health care services to  
49 recipients under Chapter 533;

50 (2) applies to be an enrolled provider  
51 under Medicaid;

52 (3) complies with the requirements of the  
53 contract between the provider and the applicable  
54 managed care organization; and

55 (4) complies with all other applicable  
56 requirements related to being a Medicaid provider.

1 Revisor's Note

2 Section 531.021191(b)(1), Government Code,  
3 refers to a health care provider or provider group that  
4 has a contract with a "managed care organization" to  
5 provide health care services to Medicaid recipients,  
6 and Section 531.021191(c)(1), Government Code, refers  
7 to an institution of higher education having a  
8 contract with a "managed care organization" to provide  
9 health care services to those recipients. As  
10 explained in the revisor's note to Section 532.0151 of  
11 this chapter, a Medicaid managed care organization is  
12 a managed care organization that contracts with the  
13 Health and Human Services Commission to provide health  
14 care services to Medicaid recipients, and the term is  
15 defined by Section 531.001(4-c), Government Code,  
16 which is revised as Section \_\_\_\_\_ and applies to  
17 Subtitle I, Title 4, Government Code, which includes  
18 this chapter. For clarity, the revised law  
19 substitutes "Medicaid managed care organization" for  
20 the references to "managed care organization" because  
21 the only type of managed care organization that would  
22 contract with a health care provider, provider group,  
23 or institution of higher education for the provision  
24 of health care services to Medicaid recipients is a  
25 Medicaid managed care organization.

26 Revised Law

27 Sec. 532.0154. RURAL HEALTH CLINIC REIMBURSEMENT. The  
28 commission may not impose any condition on the reimbursement of a  
29 rural health clinic under Medicaid if the condition is more  
30 stringent than the conditions imposed by:

31 (1) the Rural Health Clinic Services Act of 1977 (Pub.  
32 L. No. 95-210); or

33 (2) the laws of this state regulating the practice of  
34 medicine, pharmacy, or professional nursing. (Gov. Code, Sec.

1 531.02193.)

2 Source Law

3 Sec. 531.02193. CERTAIN CONDITIONS ON MEDICAID  
4 REIMBURSEMENT OF RURAL HEALTH CLINICS PROHIBITED. The  
5 commission may not impose any condition on the  
6 reimbursement of a rural health clinic under the  
7 Medicaid program if the condition is more stringent  
8 than the conditions imposed by the Rural Health Clinic  
9 Services Act of 1977 (Pub. L. No. 95-210) or the laws  
10 of this state regulating the practice of medicine,  
11 pharmacy, or professional nursing.

12 Revisor's Note

13 Section 531.02193, Government Code, refers to  
14 "the Medicaid program." Section 531.001, Government  
15 Code, revised as Section \_\_\_\_\_, defines "Medicaid" as  
16 the medical assistance program, which is synonymous  
17 with the Medicaid program. That definition applies to  
18 Subtitle I, Title 4, Government Code, which includes  
19 this chapter. For that reason, the revised law  
20 substitutes "Medicaid" for "the Medicaid program."

21 Revised Law

22 Sec. 532.0155. RURAL HOSPITAL REIMBURSEMENT. (a) In this  
23 section, "rural hospital" has the meaning assigned by commission  
24 rules for purposes of reimbursing hospitals for providing Medicaid  
25 inpatient or outpatient services.

26 (b) To the extent allowed by federal law and subject to  
27 limitations on appropriations, the executive commissioner by rule  
28 shall adopt a prospective reimbursement methodology for the payment  
29 of rural hospitals participating in Medicaid that ensures the rural  
30 hospitals are reimbursed on an individual basis for providing  
31 inpatient and general outpatient services to recipients by using  
32 the hospitals' most recent cost information concerning the costs  
33 incurred for providing the services. The commission shall  
34 calculate the prospective cost-based reimbursement rates once  
35 every two years.

36 (c) In adopting rules under Subsection (b), the executive  
37 commissioner may:

38 (1) adopt a methodology that requires:

1 (A) a Medicaid managed care organization to  
2 reimburse rural hospitals for services delivered through the  
3 Medicaid managed care program using a minimum fee schedule or other  
4 method for which federal matching money is available; or

5 (B) both the commission and a Medicaid managed  
6 care organization to share in the total amount of reimbursement  
7 paid to rural hospitals; and

8 (2) require that the reimbursement amount paid to a  
9 rural hospital is subject to any applicable adjustments the  
10 commission makes for payments to or penalties imposed on the rural  
11 hospital that are based on a quality-based or performance-based  
12 requirement under the Medicaid managed care program.

13 (d) Not later than September 1 of each even-numbered year,  
14 the commission shall, for purposes of Subsection (b), determine the  
15 allowable costs incurred by a rural hospital participating in the  
16 Medicaid managed care program based on the rural hospital's cost  
17 reports submitted to the Centers for Medicare and Medicaid Services  
18 and other available information that the commission considers  
19 relevant in determining the hospital's allowable costs.

20 (e) Notwithstanding Subsection (b) and subject to  
21 Subsection (f), the executive commissioner shall adopt and the  
22 commission shall implement, beginning with the state fiscal year  
23 ending August 31, 2022, a true cost-based reimbursement methodology  
24 for inpatient and general outpatient services provided to  
25 recipients at rural hospitals that provides:

26 (1) prospective payments during a state fiscal year to  
27 the hospitals using the reimbursement methodology adopted under  
28 Subsection (b); and

29 (2) to the extent allowed by federal law, in the  
30 subsequent state fiscal year a cost settlement to provide  
31 additional reimbursement as necessary to reimburse the hospitals  
32 for the true costs incurred in providing inpatient and general  
33 outpatient services to recipients during the previous state fiscal  
34 year.

1 (f) If federal law does not permit the use of a true  
2 cost-based reimbursement methodology described by Subsection (e),  
3 the commission shall continue to use the prospective cost-based  
4 reimbursement methodology the executive commissioner adopts under  
5 Subsection (b) for the payment of rural hospitals for providing  
6 inpatient and general outpatient services to recipients. (Gov.  
7 Code, Sec. 531.02194.)

8 Source Law

9 Sec. 531.02194. REIMBURSEMENT METHODOLOGY FOR  
10 RURAL HOSPITALS. (a) In this section, "rural  
11 hospital" has the meaning assigned by commission rules  
12 for purposes of the reimbursement of hospitals for  
13 providing inpatient or outpatient services under  
14 Medicaid.

15 (b) To the extent allowed by federal law and  
16 subject to limitations on appropriations, the  
17 executive commissioner by rule shall adopt a  
18 prospective reimbursement methodology for the payment  
19 of rural hospitals participating in Medicaid that  
20 ensures the rural hospitals are reimbursed on an  
21 individual basis for providing inpatient and general  
22 outpatient services to Medicaid recipients by using  
23 the hospitals' most recent cost information concerning  
24 the costs incurred for providing the services. The  
25 commission shall calculate the prospective cost-based  
26 reimbursement rates once every two years.

27 (c) In adopting rules under Subsection (b), the  
28 executive commissioner may:

29 (1) adopt a methodology that requires:

30 (A) a managed care organization to  
31 reimburse rural hospitals for services delivered  
32 through the Medicaid managed care program using a  
33 minimum fee schedule or other method for which federal  
34 matching money is available; or

35 (B) both the commission and a managed  
36 care organization to share in the total amount of  
37 reimbursement paid to rural hospitals; and

38 (2) require that the amount of  
39 reimbursement paid to a rural hospital is subject to  
40 any applicable adjustments made by the commission for  
41 payments to or penalties imposed on the rural hospital  
42 that are based on a quality-based or performance-based  
43 requirement under the Medicaid managed care program.

44 (d) Not later than September 1 of each  
45 even-numbered year, the commission shall, for purposes  
46 of Subsection (b), determine the allowable costs  
47 incurred by a rural hospital participating in the  
48 Medicaid managed care program based on the rural  
49 hospital's cost reports submitted to the federal  
50 Centers for Medicare and Medicaid Services and other  
51 available information that the commission considers  
52 relevant in determining the hospital's allowable  
53 costs.

54 (e) Notwithstanding Subsection (b) and subject  
55 to Subsection (f), the executive commissioner shall  
56 adopt and the commission shall implement, beginning  
57 with the state fiscal year ending August 31, 2022, a  
58 true cost-based reimbursement methodology for  
59 inpatient and general outpatient services provided to

1 Medicaid recipients at rural hospitals that provides:  
2 (1) prospective payments during a state  
3 fiscal year to the hospitals using the reimbursement  
4 methodology adopted under Subsection (b); and

5 (2) to the extent allowed by federal law,  
6 in the subsequent state fiscal year a cost settlement  
7 to provide additional reimbursement as necessary to  
8 reimburse the hospitals for the true costs incurred in  
9 providing inpatient and general outpatient services to  
10 Medicaid recipients during the previous state fiscal  
11 year.

12 (f) Notwithstanding Subsection (e), if federal  
13 law does not permit the use of a true cost-based  
14 reimbursement methodology described by that  
15 subsection, the commission shall continue to use the  
16 prospective cost-based reimbursement methodology  
17 adopted under Subsection (b) for the payment of rural  
18 hospitals for providing inpatient and general  
19 outpatient services to Medicaid recipients.

20 Revisor's Note

21 Sections 531.02194(c)(1)(A) and (B), Government  
22 Code, refer to reimbursement to rural hospitals by a  
23 "managed care organization" for services delivered  
24 through the Medicaid managed care program. The only  
25 type of managed care organization that would provide  
26 reimbursement under the Medicaid managed care program  
27 is a Medicaid managed care organization. For the  
28 reasons stated in the revisor's note to Section  
29 532.0153 of this chapter, the revised law substitutes  
30 "Medicaid managed care organization" for the  
31 references to "managed care organization."

32 Revised Law

33 Sec. 532.0156. REIMBURSEMENT SYSTEM FOR ELECTRONIC HEALTH  
34 INFORMATION REVIEW AND TRANSMISSION. If feasible and  
35 cost-effective, the executive commissioner by rule may develop and  
36 the commission may implement a system to provide Medicaid  
37 reimbursement to a health care provider, including a physician, for  
38 reviewing and transmitting electronic health information. (Gov.  
39 Code, Secs. 531.0162(g), (h)(part).)

40 Source Law

41 (g) The executive commissioner by rule may  
42 develop and the commission may implement a system to  
43 reimburse providers of health care services under the  
44 state Medicaid program for review and transmission of  
45 electronic health information if feasible and  
46 cost-effective.

1 (h) In this section, . . . "provider of health  
2 care services" include a physician.

3 Revisor's Note

4 (1) Section 531.0162(g), Government Code,  
5 refers to "the state Medicaid program." Section  
6 531.001, Government Code, revised as Section \_\_\_\_\_,  
7 defines "Medicaid" as the medical assistance program,  
8 which is synonymous with the state Medicaid program.  
9 That definition applies to Subtitle I, Title 4,  
10 Government Code, which includes this chapter. For  
11 that reason, the revised law substitutes "Medicaid"  
12 for "the state Medicaid program."

13 (2) Sections 531.0162(g) and (h), Government  
14 Code, refer to "providers of health care services" and  
15 a "provider of health care services," respectively.  
16 The revised law substitutes "health care provider" for  
17 "provider of health care services" because the terms  
18 are synonymous and the former is more commonly used in  
19 Subtitle I, Title 4, Government Code, which includes  
20 this chapter.

21 SUBCHAPTER E. DATA AND TECHNOLOGY

22 Revised Law

23 Sec. 532.0201. DATA COLLECTION SYSTEM. (a) The commission  
24 and each health and human services agency that administers a part of  
25 Medicaid shall jointly develop a system to coordinate and integrate  
26 state Medicaid databases to:

27 (1) facilitate the comprehensive analysis of Medicaid  
28 data; and

29 (2) detect fraud a program provider or recipient  
30 perpetrates.

31 (b) To minimize cost and duplication of activities, the  
32 commission shall assist and coordinate:

33 (1) the efforts of the agencies that are participating  
34 in developing the system; and

35 (2) the efforts of those agencies with the efforts of

1 other agencies involved in a statewide health care data collection  
2 system provided for by Section 108.006, Health and Safety Code,  
3 including avoiding duplication of expenditure of state money for  
4 computer hardware, staff, or services.

5 (c) On the executive commissioner's request, a state agency  
6 that administers any part of Medicaid shall assist the commission  
7 in developing the system.

8 (d) The commission shall develop the system in a manner that  
9 will enable a complete analysis of the use of prescription  
10 medications, including information relating to:

11 (1) recipients for whom more than three medications  
12 have been prescribed; and

13 (2) the medical effect denial of Medicaid coverage for  
14 more than three medications has had on recipients.

15 (e) The commission shall ensure that the system is used each  
16 month to match vital statistics unit death records with a list of  
17 individuals eligible for Medicaid, and that each individual who is  
18 deceased is promptly removed from the list of individuals eligible  
19 for Medicaid. (Gov. Code, Sec. 531.0214.)

20 Source Law

21 Sec. 531.0214. MEDICAID DATA COLLECTION SYSTEM.

22 (a) The commission and each health and human services  
23 agency that administers a part of Medicaid shall  
24 jointly develop a system to coordinate and integrate  
25 state Medicaid databases to:

26 (1) facilitate the comprehensive analysis  
27 of Medicaid data; and

28 (2) detect fraud perpetrated by a program  
29 provider or client.

30 (b) To minimize cost and duplication of  
31 activities, the commission shall assist and  
32 coordinate:

33 (1) the efforts of the agencies that are  
34 participating in the development of the system  
35 required by Subsection (a); and

36 (2) the efforts of those agencies with the  
37 efforts of other agencies involved in a statewide  
38 health care data collection system provided for by  
39 Section 108.006, Health and Safety Code, including  
40 avoiding duplication of expenditure of state funds for  
41 computer hardware, staff, or services.

42 (c) On the request of the executive  
43 commissioner, a state agency that administers any part  
44 of Medicaid shall assist the commission in developing  
45 the system required by this section.

46 (d) The commission shall develop the database  
47 system in a manner that will enable a complete analysis

1 of the use of prescription medications, including  
2 information relating to:

3 (1) Medicaid clients for whom more than  
4 three medications have been prescribed; and

5 (2) the medical effect denial of Medicaid  
6 coverage for more than three medications has had on  
7 Medicaid clients.

8 (e) The commission shall ensure that the  
9 database system is used each month to match vital  
10 statistics unit death records with a list of persons  
11 eligible for Medicaid, and that each person who is  
12 deceased is promptly removed from the list of persons  
13 eligible for Medicaid.

14 Revisor's Note

15 Section 531.0214(a), Government Code, refers to a  
16 Medicaid program "client" and Section 531.0214(d),  
17 Government Code, refers to "Medicaid clients." A  
18 "Medicaid client" is an individual who receives health  
19 care services through Medicaid. The term is synonymous  
20 with "Medicaid recipient." The revised law in Section  
21 532.0001 of this chapter adds a definition of  
22 "recipient" for purposes of the chapter and provides  
23 that the term means "a Medicaid recipient." For  
24 consistency of terminology, the revised law throughout  
25 this chapter substitutes "recipient" for "client,"  
26 "Medicaid client," and other similar references to  
27 individuals receiving health care services under  
28 Medicaid.

29 Revised Law

30 Sec. 532.0202. INFORMATION COLLECTION AND ANALYSIS. (a)

31 The commission shall:

32 (1) make every effort to improve data analysis and  
33 integrate available information associated with Medicaid;

34 (2) use the decision support system in the  
35 commission's center for analytics and decision support for the  
36 purpose described by Subdivision (1);

37 (3) modify or redesign the decision support system to  
38 allow for the data collected by Medicaid to be used more  
39 systematically and effectively for Medicaid evaluation and policy  
40 development; and

1           (4) develop or redesign the decision support system as  
2 necessary to ensure that the system:

3           (A) incorporates currently collected Medicaid  
4 enrollment, utilization, and provider data;

5           (B) allows data manipulation and quick analysis  
6 to address a large variety of questions concerning enrollment and  
7 utilization patterns and trends within Medicaid;

8           (C) is able to obtain consistent and accurate  
9 answers to questions;

10           (D) allows for analysis of multiple issues within  
11 Medicaid to determine whether any programmatic or policy issues  
12 overlap or are in conflict;

13           (E) includes predefined data reports on  
14 utilization of high-cost services that allow Medicaid management to  
15 analyze and determine the reasons for an increase or decrease in  
16 utilization and immediately proceed with policy changes, if  
17 appropriate;

18           (F) includes any encounter data with respect to  
19 recipients that a Medicaid managed care organization receives from  
20 a health care provider in the organization's provider network; and

21           (G) links Medicaid and non-Medicaid data sets,  
22 including data sets related to:

23                   (i) Medicaid;

24                   (ii) the financial assistance program under  
25 Chapter 31, Human Resources Code;

26                   (iii) the special supplemental nutrition  
27 program for women, infants, and children authorized by 42 U.S.C.  
28 Section 1786;

29                   (iv) vital statistics; and

30                   (v) other public health programs.

31           (b) The commission shall ensure that all Medicaid data sets  
32 the decision support system creates or identifies are made  
33 available on the Internet to the extent not prohibited by federal or  
34 state laws regarding medical privacy or security. If privacy

1 concerns exist or arise with respect to making the data sets  
2 available on the Internet, the system and the commission shall make  
3 every effort to make the data available on the Internet either by:

4 (1) removing individually identifiable information;  
5 or

6 (2) aggregating the data in a manner to prevent the  
7 association of individual records with particular individuals.

8 (c) The commission shall regularly evaluate data submitted  
9 by Medicaid managed care organizations to determine whether:

10 (1) the data continues to serve a useful purpose; and  
11 (2) additional data is needed to oversee contracts or  
12 evaluate the effectiveness of Medicaid.

13 (d) The commission shall collect Medicaid managed care data  
14 that effectively captures the quality of services recipients  
15 receive.

16 (e) The commission shall develop a dashboard for agency  
17 leadership that is designed to assist leadership with overseeing  
18 Medicaid and comparing the performance of Medicaid managed care  
19 organizations. The dashboard must identify a concise number of  
20 important Medicaid indicators, including key data, performance  
21 measures, trends, and problems. (Gov. Code, Sec. 531.02141.)

22 Source Law

23 Sec. 531.02141. MEDICAID INFORMATION  
24 COLLECTION AND ANALYSIS. (a) The commission shall  
25 make every effort to improve data analysis and  
26 integrate available information associated with  
27 Medicaid. The commission shall use the decision  
28 support system in the commission's center for  
29 strategic decision support for this purpose and shall  
30 modify or redesign the system to allow for the data  
31 collected by Medicaid to be used more systematically  
32 and effectively for Medicaid evaluation and policy  
33 development. The commission shall develop or redesign  
34 the system as necessary to ensure that the system:

35 (1) incorporates program enrollment,  
36 utilization, and provider data that are currently  
37 collected;

38 (2) allows data manipulation and quick  
39 analysis to address a large variety of questions  
40 concerning enrollment and utilization patterns and  
41 trends within the program;

42 (3) is able to obtain consistent and  
43 accurate answers to questions;

44 (4) allows for analysis of multiple issues  
45 within the program to determine whether any

1 programmatic or policy issues overlap or are in  
2 conflict;

3 (5) includes predefined data reports on  
4 utilization of high-cost services that allow program  
5 management to analyze and determine the reasons for an  
6 increase or decrease in utilization and immediately  
7 proceed with policy changes, if appropriate;

8 (6) includes any encounter data with  
9 respect to recipients that a managed care organization  
10 that contracts with the commission under Chapter 533  
11 receives from a health care provider under the  
12 organization's provider network; and

13 (7) links Medicaid and non-Medicaid data  
14 sets, including data sets related to Medicaid, the  
15 Temporary Assistance for Needy Families program, the  
16 Special Supplemental Nutrition Program for Women,  
17 Infants, and Children, vital statistics, and other  
18 public health programs.

19 (b) The commission shall ensure that all  
20 Medicaid data sets created or identified by the  
21 decision support system are made available on the  
22 Internet to the extent not prohibited by federal or  
23 state laws regarding medical privacy or security. If  
24 privacy concerns exist or arise with respect to making  
25 the data sets available on the Internet, the system and  
26 the commission shall make every effort to make the data  
27 available through that means either by removing  
28 information by which particular individuals may be  
29 identified or by aggregating the data in a manner so  
30 that individual records cannot be associated with  
31 particular individuals.

32 (c) The commission shall regularly evaluate  
33 data submitted by managed care organizations that  
34 contract with the commission under Chapter 533 to  
35 determine whether:

36 (1) the data continues to serve a useful  
37 purpose; and

38 (2) additional data is needed to oversee  
39 contracts or evaluate the effectiveness of Medicaid.

40 (d) The commission shall collect Medicaid  
41 managed care data that effectively captures the  
42 quality of services received by Medicaid recipients.

43 (e) The commission shall develop a dashboard for  
44 agency leadership that is designed to assist  
45 leadership with overseeing Medicaid and comparing the  
46 performance of managed care organizations  
47 participating in Medicaid. The dashboard must  
48 identify a concise number of important Medicaid  
49 indicators, including key data, performance measures,  
50 trends, and problems.

51 Revisor's Note

52 (1) Section 531.02141(a), Government Code,  
53 refers to the "center for strategic decision support"  
54 within the Health and Human Services Commission.  
55 According to the commission, the current name of the  
56 center is the "center for analytics and decision  
57 support." The revised law is drafted accordingly.

58 (2) Section 531.02141(a)(7), Government Code,  
59 refers to the "Temporary Assistance for Needy Families

1 program," meaning the financial assistance program  
2 under Chapter 31, Human Resources Code. For clarity,  
3 the revised law substitutes "financial assistance  
4 program under Chapter 31, Human Resources Code" for  
5 "Temporary Assistance for Needy Families program."

6 (3) Section 531.02141(a)(7), Government Code,  
7 refers to the "Special Supplemental Nutrition Program  
8 for Women, Infants, and Children," meaning the federal  
9 program authorized by 42 U.S.C. Section 1786. For  
10 clarity, the revised law adds a reference to the  
11 federal statute.

12 Revised Law

13 Sec. 532.0203. PUBLIC ACCESS TO CERTAIN DATA. (a) To the  
14 extent permitted by federal law, the commission, in collaboration  
15 with the appropriate advisory committees related to Medicaid, shall  
16 make available to the public on the commission's Internet website  
17 in an easy-to-read format data relating to the quality of health  
18 care recipients received and the health outcomes of those  
19 recipients. Data the commission makes available to the public must  
20 be made available in a manner that does not identify or allow for  
21 the identification of individual recipients.

22 (b) In performing duties under this section, the commission  
23 may collaborate with an institution of higher education or another  
24 state agency with experience in analyzing and producing public use  
25 data. (Gov. Code, Sec. 531.02142.)

26 Source Law

27 Sec. 531.02142. PUBLIC ACCESS TO CERTAIN  
28 MEDICAID DATA. (a) To the extent permitted by federal  
29 law, the commission in consultation and collaboration  
30 with the appropriate advisory committees related to  
31 Medicaid shall make available to the public on the  
32 commission's Internet website in an easy-to-read  
33 format data relating to the quality of health care  
34 received by Medicaid recipients and the health  
35 outcomes of those recipients. Data made available to  
36 the public under this section must be made available in  
37 a manner that does not identify or allow for the  
38 identification of individual recipients.

39 (b) In performing its duties under this section,  
40 the commission may collaborate with an institution of  
41 higher education or another state agency with

1 experience in analyzing and producing public use data.

2 Revisor's Note

3 Section 531.02142(a), Government Code, provides  
4 that the Health and Human Services Commission shall  
5 take certain action in "consultation and  
6 collaboration" with certain advisory committees. The  
7 revised law omits "consultation" in this context as  
8 redundant because "consultation" is included within  
9 the meaning of "collaboration."

10 Revised Law

11 Sec. 532.0204. DATA REGARDING TREATMENT FOR PRENATAL  
12 ALCOHOL OR CONTROLLED SUBSTANCE EXPOSURE. (a) The commission  
13 shall collect hospital discharge data for recipients regarding  
14 treatment of a newborn child for prenatal exposure to alcohol or a  
15 controlled substance.

16 (b) The commission shall provide the collected data to the  
17 Department of Family and Protective Services. (Gov. Code, Sec.  
18 531.02143.)

19 Source Law

20 Sec. 531.02143. DATA REGARDING POSTNATAL  
21 ALCOHOL AND CONTROLLED SUBSTANCE TREATMENT. (a) The  
22 commission shall collect hospital discharge data for  
23 Medicaid recipients regarding treatment of a newborn  
24 child for prenatal exposure to alcohol or a controlled  
25 substance.

26 (b) The commission shall provide the data  
27 collected under Subsection (a) to the Department of  
28 Family and Protective Services.

29 Revised Law

30 Sec. 532.0205. MEDICAL TECHNOLOGY. The commission shall  
31 explore and evaluate new developments in medical technology and  
32 propose implementing the technology in Medicaid, if appropriate and  
33 cost-effective. Commission staff implementing this section must  
34 have skills and experience in research regarding health care  
35 technology. (Gov. Code, Sec. 531.0081.)

36 Source Law

37 Sec. 531.0081. MEDICAL TECHNOLOGY. (b) The  
38 commission shall explore and evaluate new developments  
39 in medical technology and propose implementing the  
40 technology in Medicaid, if appropriate and

1 cost-effective.

2 (c) Commission staff implementing this section  
3 must have skills and experience in research regarding  
4 health care technology.

5 Revised Law

6 Sec. 532.0206. PILOT PROJECTS RELATING TO TECHNOLOGY  
7 APPLICATIONS. (a) Notwithstanding any other law, the commission  
8 may establish one or more pilot projects through which Medicaid  
9 reimbursement is made to demonstrate the applications of technology  
10 in providing Medicaid services.

11 (b) A pilot project under this section may relate to  
12 providing rehabilitation services, services for the aging or  
13 individuals with disabilities, or long-term care services,  
14 including community care services and supports.

15 (c) Notwithstanding an eligibility requirement prescribed  
16 by any other law or rule, the commission may establish requirements  
17 for an individual to receive services provided through a pilot  
18 project under this section.

19 (d) An individual's receipt of services provided through a  
20 pilot project under this section does not entitle the individual to  
21 other services under a government-funded health program.

22 (e) The commission may set a maximum enrollment limit for a  
23 pilot project under this section. (Gov. Code, Sec. 531.062.)

24 Source Law

25 Sec. 531.062. PILOT PROJECTS RELATING TO  
26 TECHNOLOGY APPLICATIONS. (a) Notwithstanding any  
27 other law, the commission may establish one or more  
28 pilot projects through which reimbursement under  
29 Medicaid is made to demonstrate the applications of  
30 technology in providing services under that program.

31 (b) A pilot project established under this  
32 section may relate to providing rehabilitation  
33 services, services for the aging or persons with  
34 disabilities, or long-term care services, including  
35 community care services and support.

36 (c) Notwithstanding an eligibility requirement  
37 prescribed by any other law or rule, the commission may  
38 establish requirements for a person to receive  
39 services provided through a pilot project under this  
40 section.

41 (d) Receipt of services provided through a pilot  
42 project under this section does not entitle the  
43 recipient to other services under a government-funded  
44 health program.

45 (e) The commission may set a maximum enrollment  
46 limit for a pilot project established under this  
47 section.

1 SUBCHAPTER F. ELECTRONIC VISIT VERIFICATION SYSTEM

2 Revised Law

3 Sec. 532.0251. DEFINITION. In this subchapter, "electronic  
4 visit verification system" means the electronic visit verification  
5 system implemented under Section 532.0253. (New.)

6 Revisor's Note

7 The definition of "electronic visit verification  
8 system" is added to the revised law for drafting  
9 convenience and to eliminate frequent, unnecessary  
10 repetition of the substance of the definition.

11 Revised Law

12 Sec. 532.0252. IMPLEMENTATION OF CERTAIN PROVISIONS.  
13 Notwithstanding any other provision of this subchapter, the  
14 commission is required to implement a change in law made to former  
15 Section 531.024172 by Chapter 909 (S.B. 894), Acts of the 85th  
16 Legislature, Regular Session, 2017, only if the commission  
17 determines the implementation is appropriate based on the findings  
18 of the electronic visit verification system review conducted before  
19 April 1, 2018, under Section 531.024172(a) as that section existed  
20 before that date. (Gov. Code, Sec. 531.024172(a) (part).)

21 Source Law

22 (a) . . . Notwithstanding any other provision  
23 of this section, the commission is required to  
24 implement a change in law made to this section by S.B.  
25 894, Acts of the 85th Legislature, Regular Session,  
26 2017, only if the commission determines the  
27 implementation is appropriate based on the findings of  
28 the review. . . .

29 Revisor's Note

30 Section 531.024172(a), Government Code, requires  
31 the Health and Human Services Commission to conduct a  
32 review of the electronic visit verification system not  
33 later than March 31, 2018, and states that the  
34 commission may combine the review with any similar  
35 review. The revised law omits these provisions as  
36 executed. The omitted law reads:

37 Sec. 531.024172. ELECTRONIC VISIT

1 VERIFICATION SYSTEM. (a) Not later than  
2 March 31, 2018, the commission shall  
3 conduct a review of the electronic visit  
4 verification system in use under this  
5 section on August 31, 2017. . . . The  
6 commission may combine the review required  
7 by this subsection with any similar review  
8 required to be conducted by the commission.

9 Revised Law

10 Sec. 532.0253. ELECTRONIC VISIT VERIFICATION SYSTEM  
11 IMPLEMENTATION. (a) Subject to Section 532.0258(a), the  
12 commission shall, in accordance with federal law, implement an  
13 electronic visit verification system to electronically verify that  
14 personal care services, attendant care services, or other services  
15 the commission identifies that are provided under Medicaid to  
16 recipients, including personal care services or attendant care  
17 services provided under the Texas Health Care Transformation and  
18 Quality Improvement Program waiver issued under Section 1115 of the  
19 Social Security Act (42 U.S.C. Section 1315) or any other Medicaid  
20 waiver program, are provided to recipients in accordance with a  
21 prior authorization or plan of care.

22 (b) The verification must be made through a telephone,  
23 global positioning, or computer-based system. (Gov. Code, Sec.  
24 531.024172(b) (part).)

25 Source Law

26 (b) Subject to Subsection (g), the commission  
27 shall, in accordance with federal law, implement an  
28 electronic visit verification system to  
29 electronically verify through a telephone, global  
30 positioning, or computer-based system that personal  
31 care services, attendant care services, or other  
32 services identified by the commission that are  
33 provided to recipients under Medicaid, including  
34 personal care services or attendant care services  
35 provided under the Texas Health Care Transformation  
36 and Quality Improvement Program waiver issued under  
37 Section 1115 of the federal Social Security Act (42  
38 U.S.C. Section 1315) or any other Medicaid waiver  
39 program, are provided to recipients in accordance with  
40 a prior authorization or plan of care. . . .

41 Revised Law

42 Sec. 532.0254. INFORMATION TO BE VERIFIED. The electronic  
43 visit verification system must allow for verification of only the  
44 following information relating to the delivery of Medicaid  
45 services:

- 1 (1) the type of service provided;
- 2 (2) the name of the recipient to whom the service was  
3 provided;
- 4 (3) the date and times the provider began and ended the  
5 service delivery visit;
- 6 (4) the location, including the address, at which the  
7 service was provided;
- 8 (5) the name of the individual who provided the  
9 service; and
- 10 (6) other information the commission determines is  
11 necessary to ensure the accurate adjudication of Medicaid claims.  
12 (Gov. Code, Sec. 531.024172(b) (part).)

13 Source Law

- 14 (b) . . . The electronic visit verification  
15 system implemented under this subsection must allow  
16 for verification of only the following information  
17 relating to the delivery of Medicaid services:
- 18 (1) the type of service provided;
- 19 (2) the name of the recipient to whom the  
20 service is provided;
- 21 (3) the date and times the provider began  
22 and ended the service delivery visit;
- 23 (4) the location, including the address,  
24 at which the service was provided;
- 25 (5) the name of the individual who  
26 provided the service; and
- 27 (6) other information the commission  
28 determines is necessary to ensure the accurate  
29 adjudication of Medicaid claims.

30 Revised Law

31 Sec. 532.0255. COMPLIANCE STANDARDS AND STANDARDIZED  
32 PROCESSES. (a) In implementing the electronic visit verification  
33 system:

34 (1) subject to Subsection (b), the executive  
35 commissioner shall adopt compliance standards for health care  
36 providers; and

37 (2) the commission shall ensure that:

38 (A) the information required to be reported by  
39 health care providers is standardized across Medicaid managed care  
40 organizations and commission programs;

41 (B) processes Medicaid managed care

1 organizations require to retrospectively correct data are  
2 standardized and publicly accessible to health care providers;

3 (C) standardized processes are established for  
4 addressing the failure of a Medicaid managed care organization to  
5 provide a timely authorization for delivering services necessary to  
6 ensure continuity of care; and

7 (D) a health care provider is allowed to enter a  
8 variable schedule into the system.

9 (b) In establishing compliance standards for health care  
10 providers under Subsection (a), the executive commissioner shall  
11 consider:

12 (1) the administrative burdens placed on health care  
13 providers required to comply with the standards; and

14 (2) the benefits of using emerging technologies for  
15 ensuring compliance, including Internet-based, mobile  
16 telephone-based, and global positioning-based technologies. (Gov.  
17 Code, Secs. 531.024172(d), (e).)

18 Source Law

19 (d) In implementing the electronic visit  
20 verification system:

21 (1) subject to Subsection (e), the  
22 executive commissioner shall adopt compliance  
23 standards for health care providers; and

24 (2) the commission shall ensure that:

25 (A) the information required to be  
26 reported by health care providers is standardized  
27 across managed care organizations that contract with  
28 the commission to provide health care services to  
29 Medicaid recipients and across commission programs;

30 (B) processes required by managed  
31 care organizations to retrospectively correct data are  
32 standardized and publicly accessible to health care  
33 providers;

34 (C) standardized processes are  
35 established for addressing the failure of a managed  
36 care organization to provide a timely authorization  
37 for delivering services necessary to ensure continuity  
38 of care; and

39 (D) a health care provider is allowed  
40 to enter a variable schedule into the electronic visit  
41 verification system.

42 (e) In establishing compliance standards for  
43 health care providers under Subsection (d), the  
44 executive commissioner shall consider:

45 (1) the administrative burdens placed on  
46 health care providers required to comply with the  
47 standards; and

48 (2) the benefits of using emerging  
49 technologies for ensuring compliance, including

1 Internet-based, mobile telephone-based, and global  
2 positioning-based technologies.

3 Revised Law

4 Sec. 532.0256. RECIPIENT COMPLIANCE. The commission shall  
5 inform each recipient who receives personal care services,  
6 attendant care services, or other services the commission  
7 identifies that the health care provider providing the services and  
8 the recipient are each required to comply with the electronic visit  
9 verification system. A Medicaid managed care organization shall  
10 also inform recipients described by this section who are enrolled  
11 in a managed care plan offered by the organization of those  
12 requirements. (Gov. Code, Sec. 531.024172(c).)

13 Source Law

14 (c) The commission shall inform each Medicaid  
15 recipient who receives personal care services,  
16 attendant care services, or other services identified  
17 by the commission that the health care provider  
18 providing the services and the recipient are each  
19 required to comply with the electronic visit  
20 verification system. A managed care organization that  
21 contracts with the commission to provide health care  
22 services to Medicaid recipients described by this  
23 subsection shall also inform recipients enrolled in a  
24 managed care plan offered by the organization of those  
25 requirements.

26 Revised Law

27 Sec. 532.0257. HEALTH CARE PROVIDER COMPLIANCE. A health  
28 care provider that provides to recipients personal care services,  
29 attendant care services, or other services the commission  
30 identifies shall:

31 (1) use the electronic visit verification system or a  
32 proprietary system the commission allows as provided by Section  
33 532.0258 to document the provision of those services;

34 (2) comply with all documentation requirements the  
35 commission establishes;

36 (3) comply with federal and state laws regarding  
37 confidentiality of recipients' information;

38 (4) ensure that the commission or the Medicaid managed  
39 care organization with which a claim for reimbursement for a  
40 service is filed may review electronic visit verification system

1 documentation related to the claim or obtain a copy of that  
2 documentation at no charge to the commission or the organization;  
3 and

4 (5) at any time, allow the commission or a Medicaid  
5 managed care organization with which a health care provider  
6 contracts to provide health care services to recipients enrolled in  
7 the organization's managed care plan to have direct, on-site access  
8 to the electronic visit verification system in use by the health  
9 care provider. (Gov. Code, Sec. 531.024172(f).)

10 Source Law

11 (f) A health care provider that provides  
12 personal care services, attendant care services, or  
13 other services identified by the commission to  
14 Medicaid recipients shall:

15 (1) use an electronic visit verification  
16 system to document the provision of those services;

17 (2) comply with all documentation  
18 requirements established by the commission;

19 (3) comply with applicable federal and  
20 state laws regarding confidentiality of recipients'  
21 information;

22 (4) ensure that the commission or the  
23 managed care organization with which a claim for  
24 reimbursement for a service is filed may review  
25 electronic visit verification system documentation  
26 related to the claim or obtain a copy of that  
27 documentation at no charge to the commission or the  
28 organization; and

29 (5) at any time, allow the commission or a  
30 managed care organization with which a health care  
31 provider contracts to provide health care services to  
32 recipients enrolled in the organization's managed care  
33 plan to have direct, on-site access to the electronic  
34 visit verification system in use by the health care  
35 provider.

36 Revisor's Note

37 Section 531.024172(f)(1), Government Code,  
38 requires certain health care providers to use "an  
39 electronic visit verification system." Section  
40 531.024172(g), Government Code, revised as Section  
41 532.0258(a) of this chapter, authorizes a health care  
42 provider to use a proprietary electronic visit  
43 verification system if allowed by the Health and Human  
44 Services Commission. It is clear that "an electronic  
45 visit verification system" referenced in Section  
46 531.024172(f)(1) could mean either the system

1 implemented under Section 531.024172, which is revised  
2 in relevant part as Section 532.0253 of this chapter,  
3 or the proprietary system authorized by Section  
4 531.024172(g). For clarity, the revised law refers to  
5 "the electronic visit verification system," which is  
6 defined by Section 532.0251 of this chapter to mean the  
7 system implemented under Section 532.0253 of this  
8 chapter, and to "a proprietary system the commission  
9 allows as provided by Section 532.0258."

10 Revised Law

11 Sec. 532.0258. HEALTH CARE PROVIDER: USE OF PROPRIETARY  
12 SYSTEM. (a) The commission may recognize a health care provider's  
13 proprietary electronic visit verification system, whether  
14 purchased or developed by the provider, as complying with this  
15 subchapter and allow the health care provider to use that system for  
16 a period the commission determines if the commission determines  
17 that the system:

18 (1) complies with all necessary data submission,  
19 exchange, and reporting requirements established under this  
20 subchapter; and

21 (2) meets all other standards and requirements  
22 established under this subchapter.

23 (b) If feasible, the executive commissioner shall ensure a  
24 health care provider is reimbursed for the use of the provider's  
25 proprietary electronic visit verification system the commission  
26 recognizes.

27 (c) For purposes of facilitating the use of proprietary  
28 electronic visit verification systems by health care providers and  
29 in consultation with industry stakeholders and the work group  
30 established under Section 532.0259, the commission or the executive  
31 commissioner, as appropriate, shall:

32 (1) develop an open model system that mitigates the  
33 administrative burdens providers required to use electronic visit  
34 verification identify;

1 (2) allow providers to use emerging technologies,  
2 including Internet-based, mobile telephone-based, and global  
3 positioning-based technologies, in the providers' proprietary  
4 electronic visit verification systems; and

5 (3) adopt rules governing data submission and provider  
6 reimbursement. (Gov. Code, Secs. 531.024172(g), (g-1), (g-2).)

7 Source Law

8 (g) The commission may recognize a health care  
9 provider's proprietary electronic visit verification  
10 system, whether purchased or developed by the  
11 provider, as complying with this section and allow the  
12 health care provider to use that system for a period  
13 determined by the commission if the commission  
14 determines that the system:

15 (1) complies with all necessary data  
16 submission, exchange, and reporting requirements  
17 established under this section; and

18 (2) meets all other standards and  
19 requirements established under this section.

20 (g-1) If feasible, the executive commissioner  
21 shall ensure a health care provider that uses the  
22 provider's proprietary electronic visit verification  
23 system recognized under Subsection (g) is reimbursed  
24 for the use of that system.

25 (g-2) For purposes of facilitating the use of  
26 proprietary electronic visit verification systems by  
27 health care providers under Subsection (g) and in  
28 consultation with industry stakeholders and the work  
29 group established under Subsection (h), the commission  
30 or the executive commissioner, as appropriate, shall:

31 (1) develop an open model system that  
32 mitigates the administrative burdens identified by  
33 providers required to use electronic visit  
34 verification;

35 (2) allow providers to use emerging  
36 technologies, including Internet-based, mobile  
37 telephone-based, and global positioning-based  
38 technologies, in the providers' proprietary electronic  
39 visit verification systems; and

40 (3) adopt rules governing data submission  
41 and provider reimbursement.

42 Revised Law

43 Sec. 532.0259. STAKEHOLDER INPUT. The commission shall  
44 create a stakeholder work group composed of representatives of  
45 affected health care providers, Medicaid managed care  
46 organizations, and recipients. The commission shall periodically  
47 solicit from the work group input regarding the ongoing operation  
48 of the electronic visit verification system. (Gov. Code, Sec.  
49 531.024172(h).)

1 Source Law

2 (h) The commission shall create a stakeholder  
3 work group comprised of representatives of affected  
4 health care providers, managed care organizations, and  
5 Medicaid recipients and periodically solicit from that  
6 work group input regarding the ongoing operation of  
7 the electronic visit verification system under this  
8 section.

9 Revisor's Note

10 Section 531.024172(h), Government Code, refers  
11 to "affected . . . managed care organizations,"  
12 meaning managed care organizations affected by the  
13 electronic visit verification system described in  
14 Section 531.024172, which is revised as this  
15 subchapter. The only type of managed care organization  
16 that would be affected by the electronic visit  
17 verification system is a Medicaid managed care  
18 organization. For the reasons stated in the revisor's  
19 note to Section 532.0153 of this chapter, the revised  
20 law substitutes "Medicaid managed care organizations"  
21 for the reference to "managed care organizations."

22 Revised Law

23 Sec. 532.0260. RULES. The executive commissioner may adopt  
24 rules necessary to implement this subchapter. (Gov. Code, Sec.  
25 531.024172(i).)

26 Source Law

27 (i) The executive commissioner may adopt rules  
28 necessary to implement this section.

29 SUBCHAPTER G. APPLICANTS AND RECIPIENTS

30 Revised Law

31 Sec. 532.0301. BILL OF RIGHTS AND BILL OF RESPONSIBILITIES.

32 (a) The executive commissioner by rule shall adopt a bill of rights  
33 and a bill of responsibilities for each recipient.

34 (b) The bill of rights must address a recipient's right to:

35 (1) respect, dignity, privacy, confidentiality, and  
36 nondiscrimination;

37 (2) a reasonable opportunity to choose a health

1 benefits plan and primary care provider and to change to another  
2 plan or provider in a reasonable manner;

3 (3) consent to or refuse treatment and actively  
4 participate in treatment decisions;

5 (4) ask questions and receive complete information  
6 relating to the recipient's medical condition and treatment  
7 options, including specialty care;

8 (5) access each available complaint process, receive a  
9 timely response to a complaint, and receive a fair hearing; and

10 (6) timely access to care that does not have any  
11 communication or physical access barriers.

12 (c) The bill of responsibilities must address a recipient's  
13 responsibility to:

14 (1) learn and understand each right the recipient has  
15 under Medicaid;

16 (2) abide by the health benefits plan and Medicaid  
17 policies and procedures;

18 (3) share information relating to the recipient's  
19 health status with the primary care provider and become fully  
20 informed about service and treatment options; and

21 (4) actively participate in decisions relating to  
22 service and treatment options, make personal choices, and take  
23 action to maintain the recipient's health. (Gov. Code, Sec.  
24 531.0212.)

25 Source Law

26 Sec. 531.0212. MEDICAID BILL OF RIGHTS AND BILL  
27 OF RESPONSIBILITIES. (a) The executive commissioner  
28 by rule shall adopt a bill of rights and a bill of  
29 responsibilities for each person enrolled in Medicaid.

30 (b) The bill of rights must address a client's  
31 right to:

32 (1) respect, dignity, privacy,  
33 confidentiality, and nondiscrimination;

34 (2) a reasonable opportunity to choose a  
35 health care plan and primary care provider and to  
36 change to another plan or provider in a reasonable  
37 manner;

38 (3) consent to or refuse treatment and  
39 actively participate in treatment decisions;

40 (4) ask questions and receive complete  
41 information relating to the client's medical condition  
42 and treatment options, including specialty care;

1 (5) access each available complaint  
2 process, receive a timely response to a complaint, and  
3 receive a fair hearing; and

4 (6) timely access to care that does not  
5 have any communication or physical access barriers.

6 (c) The bill of responsibilities must address a  
7 client's responsibility to:

8 (1) learn and understand each right the  
9 client has under Medicaid;

10 (2) abide by the health plan and Medicaid  
11 policies and procedures;

12 (3) share information relating to the  
13 client's health status with the primary care provider  
14 and become fully informed about service and treatment  
15 options; and

16 (4) actively participate in decisions  
17 relating to service and treatment options, make  
18 personal choices, and take action to maintain the  
19 client's health.

20 Revisor's Note

21 Section 531.0212(b)(2), Government Code, refers  
22 to a Medicaid recipient's opportunity to choose a  
23 "health care plan," and Section 531.0212(c)(2),  
24 Government Code, refers to that recipient's  
25 responsibility to follow the "health plan" policies  
26 and procedures. The revised law substitutes "health  
27 benefits plan" for the quoted phrases because that is  
28 the term more commonly used to reference that type of  
29 plan offered by a managed care organization.

30 Revised Law

31 Sec. 532.0302. UNIFORM FAIR HEARING RULES. (a) The  
32 executive commissioner shall adopt uniform fair hearing rules for  
33 Medicaid-funded services. The rules must provide:

34 (1) due process to a Medicaid applicant and to a  
35 recipient who seeks a Medicaid service, including a service that  
36 requires prior authorization; and

37 (2) the protections for applicants and recipients  
38 required by 42 C.F.R. Part 431, Subpart E, including requiring  
39 that:

40 (A) the written notice to an individual of the  
41 individual's right to a hearing must:

42 (i) contain an explanation of the  
43 circumstances under which Medicaid is continued if a hearing is

1 requested; and

2 (ii) be delivered by mail, and postmarked  
3 at least 10 business days, before the date the individual's  
4 Medicaid eligibility or service is scheduled to be terminated,  
5 suspended, or reduced, except as provided by 42 C.F.R. Section  
6 431.213 or 431.214; and

7 (B) if a hearing is requested before the date a  
8 recipient's service, including a service that requires prior  
9 authorization, is scheduled to be terminated, suspended, or  
10 reduced, the agency may not take that proposed action before a  
11 decision is rendered after the hearing unless:

12 (i) it is determined at the hearing that the  
13 sole issue is one of federal or state law or policy; and

14 (ii) the agency promptly informs the  
15 recipient in writing that services are to be terminated, suspended,  
16 or reduced pending the hearing decision.

17 (b) The commission shall develop a process to address a  
18 situation in which:

19 (1) an individual does not receive adequate notice as  
20 required by Subsection (a)(2)(A); or

21 (2) the notice required by Subsection (a)(2)(A) is  
22 delivered without a postmark. (Gov. Code, Secs. 531.024(a) (part),  
23 (b), (c).)

24 Source Law

25 Sec. 531.024. PLANNING AND DELIVERY OF HEALTH  
26 SERVICES; DATA SHARING. (a) The executive  
27 commissioner shall:

28 . . .  
29 (7) promulgate uniform fair hearing rules  
30 for all Medicaid-funded services.

31 (b) The rules promulgated under Subsection  
32 (a)(7) must provide due process to an applicant for  
33 Medicaid services and to a Medicaid recipient who  
34 seeks a Medicaid service, including a service that  
35 requires prior authorization. The rules must provide  
36 the protections for applicants and recipients required  
37 by 42 C.F.R. Part 431, Subpart E, including requiring  
38 that:

39 (1) the written notice to an individual of  
40 the individual's right to a hearing must:

41 (A) contain an explanation of the  
42 circumstances under which Medicaid is continued if a  
43 hearing is requested; and

1 (B) be delivered by mail, and  
2 postmarked at least 10 business days, before the date  
3 the individual's Medicaid eligibility or service is  
4 scheduled to be terminated, suspended, or reduced,  
5 except as provided by 42 C.F.R. Section 431.213 or  
6 431.214; and

7 (2) if a hearing is requested before the  
8 date a Medicaid recipient's service, including a  
9 service that requires prior authorization, is  
10 scheduled to be terminated, suspended, or reduced, the  
11 agency may not take that proposed action before a  
12 decision is rendered after the hearing unless:

13 (A) it is determined at the hearing  
14 that the sole issue is one of federal or state law or  
15 policy; and

16 (B) the agency promptly informs the  
17 recipient in writing that services are to be  
18 terminated, suspended, or reduced pending the hearing  
19 decision.

20 (c) The commission shall develop a process to  
21 address a situation in which:

22 (1) an individual does not receive  
23 adequate notice as required by Subsection (b)(1); or

24 (2) the notice required by Subsection  
25 (b)(1) is delivered without a postmark.

26 Revised Law

27 Sec. 532.0303. SUPPORT AND INFORMATION SERVICES FOR  
28 RECIPIENTS. (a) The commission shall provide support and  
29 information services to a recipient or applicant for Medicaid who  
30 experiences barriers to receiving health care services. The  
31 commission shall give emphasis to assisting an individual with an  
32 urgent or immediate medical or support need.

33 (b) The commission shall provide the support and  
34 information services through a network of entities that are:

35 (1) coordinated by the commission's office of the  
36 ombudsman or other commission division the executive commissioner  
37 designates; and

38 (2) composed of:

39 (A) the commission's office of the ombudsman or  
40 other commission division the executive commissioner designates to  
41 coordinate the network;

42 (B) the office of the state long-term care  
43 ombudsman required under Subchapter F, Chapter 101A, Human  
44 Resources Code;

45 (C) the commission division responsible for  
46 oversight of Medicaid managed care contracts;

1 (D) area agencies on aging;

2 (E) aging and disability resource centers  
3 established under the aging and disability resource center  
4 initiative funded in part by the Administration on Aging and the  
5 Centers for Medicare and Medicaid Services; and

6 (F) any other entity the executive commissioner  
7 determines appropriate, including nonprofit organizations with  
8 which the commission contracts under Subsection (c).

9 (c) The commission may provide the support and information  
10 services by contracting with nonprofit organizations that are not  
11 involved in providing health care, health insurance, or health  
12 benefits.

13 (d) As a part of the support and information services, the  
14 commission shall:

15 (1) operate a statewide toll-free assistance  
16 telephone number that includes relay services for individuals with  
17 speech or hearing disabilities and assistance for individuals who  
18 speak Spanish;

19 (2) intervene promptly with the state Medicaid office,  
20 Medicaid managed care organizations and providers, and any other  
21 appropriate entity on behalf of an individual who has an urgent need  
22 for medical services;

23 (3) assist an individual who is experiencing barriers  
24 in the Medicaid application and enrollment process and refer the  
25 individual for further assistance if appropriate;

26 (4) educate individuals so that they:

27 (A) understand the concept of managed care;

28 (B) understand their rights under Medicaid,  
29 including grievance and appeal procedures; and

30 (C) are able to advocate for themselves;

31 (5) collect and maintain statistical information on a  
32 regional basis regarding calls the assistance lines receive and  
33 publish quarterly reports that:

34 (A) list the number of calls received by region;

1 (B) identify trends in delivery and access  
2 problems;

3 (C) identify recurring barriers in the Medicaid  
4 system; and

5 (D) indicate other identified problems with  
6 Medicaid managed care;

7 (6) assist the state Medicaid office and Medicaid  
8 managed care organizations and providers in identifying and  
9 correcting problems, including site visits to affected regions if  
10 necessary;

11 (7) meet the needs of all current and future managed  
12 care recipients, including children receiving dental benefits and  
13 other recipients receiving benefits, under:

14 (A) the STAR Medicaid managed care program;

15 (B) the STAR+PLUS Medicaid managed care program,  
16 including the Texas Dual Eligible Integrated Care Demonstration  
17 Project provided under that program;

18 (C) the STAR Kids managed care program  
19 established under Section \_\_\_\_ [[[Section 533.00253]]]; and

20 (D) the STAR Health program;

21 (8) incorporate support services for children  
22 enrolled in the child health plan program established under Chapter  
23 62, Health and Safety Code; and

24 (9) ensure that staff providing support and  
25 information services receive sufficient training, including  
26 training in the Medicare program for the purpose of assisting  
27 recipients who are dually eligible for Medicare and Medicaid, and  
28 have sufficient authority to resolve barriers experienced by  
29 recipients to health care and long-term services and supports.

30 (e) The commission's office of the ombudsman or other  
31 commission division the executive commissioner designates to  
32 coordinate the network of entities responsible for providing the  
33 support and information services must be sufficiently independent  
34 from other aspects of Medicaid managed care to represent the best

1 interests of recipients in problem resolution. (Gov. Code, Sec.  
2 531.0213.)

3 Source Law

4 Sec. 531.0213. SUPPORT SERVICES FOR MEDICAID  
5 RECIPIENTS. (a) The commission shall provide support  
6 and information services to a person enrolled in or  
7 applying for Medicaid coverage who experiences  
8 barriers to receiving health care services.

9 (b) The commission shall give emphasis to  
10 assisting a person with an urgent or immediate medical  
11 or support need.

12 (b-1) The commission shall provide support and  
13 information services required by this section through  
14 a network of entities coordinated by the commission's  
15 office of the ombudsman or other division of the  
16 commission designated by the executive commissioner  
17 and composed of:

18 (1) the commission's office of the  
19 ombudsman or other division of the commission  
20 designated by the executive commissioner to coordinate  
21 the network;

22 (2) the office of the state long-term care  
23 ombudsman required under Subchapter F, Chapter 101A,  
24 Human Resources Code;

25 (3) the division within the commission  
26 responsible for oversight of Medicaid managed care  
27 contracts;

28 (4) area agencies on aging;

29 (5) aging and disability resource centers  
30 established under the Aging and Disability Resource  
31 Center initiative funded in part by the federal  
32 Administration on Aging and the Centers for Medicare  
33 and Medicaid Services; and

34 (6) any other entity the executive  
35 commissioner determines appropriate, including  
36 nonprofit organizations with which the commission  
37 contracts under Subsection (c).

38 (c) The commission may provide support and  
39 information services by contracting with nonprofit  
40 organizations that are not involved in providing  
41 health care, health insurance, or health benefits.

42 (d) As a part of the support and information  
43 services required by this section, the commission  
44 shall:

45 (1) operate a statewide toll-free  
46 assistance telephone number that includes relay  
47 services for persons with speech or hearing  
48 disabilities and assistance for persons who speak  
49 Spanish;

50 (2) intervene promptly with the state  
51 Medicaid office, managed care organizations and  
52 providers, and any other appropriate entity on behalf  
53 of a person who has an urgent need for medical  
54 services;

55 (3) assist a person who is experiencing  
56 barriers in the Medicaid application and enrollment  
57 process and refer the person for further assistance if  
58 appropriate;

59 (4) educate persons so that they:

60 (A) understand the concept of managed  
61 care;

62 (B) understand their rights under  
63 Medicaid, including grievance and appeal procedures;  
64 and

1 (C) are able to advocate for  
2 themselves;

3 (5) collect and maintain statistical  
4 information on a regional basis regarding calls  
5 received by the assistance lines and publish quarterly  
6 reports that:

7 (A) list the number of calls received  
8 by region;

9 (B) identify trends in delivery and  
10 access problems;

11 (C) identify recurring barriers in  
12 the Medicaid system; and

13 (D) indicate other problems  
14 identified with Medicaid managed care;

15 (6) assist the state Medicaid office and  
16 managed care organizations and providers in  
17 identifying and correcting problems, including site  
18 visits to affected regions if necessary;

19 (7) meet the needs of all current and  
20 future Medicaid managed care recipients, including  
21 children receiving dental benefits and other  
22 recipients receiving benefits, under the:

23 (A) STAR Medicaid managed care  
24 program;

25 (B) STAR + PLUS Medicaid managed care  
26 program, including the Texas Dual Eligibles Integrated  
27 Care Demonstration Project provided under that  
28 program;

29 (C) STAR Kids managed care program  
30 established under Section 533.00253; and

31 (D) STAR Health program;

32 (8) incorporate support services for  
33 children enrolled in the child health plan established  
34 under Chapter 62, Health and Safety Code; and

35 (9) ensure that staff providing support  
36 and information services receives sufficient  
37 training, including training in the Medicare program  
38 for the purpose of assisting recipients who are dually  
39 eligible for Medicare and Medicaid, and has sufficient  
40 authority to resolve barriers experienced by  
41 recipients to health care and long-term services and  
42 supports.

43 (e) The commission's office of the ombudsman, or  
44 other division of the commission designated by the  
45 executive commissioner to coordinate the network of  
46 entities responsible for providing support and  
47 information services under this section, must be  
48 sufficiently independent from other aspects of  
49 Medicaid managed care to represent the best interests  
50 of recipients in problem resolution.

51 Revisor's Note

52 Section 531.0213(d)(2), Government Code,  
53 requires the Health and Human Services Commission, as  
54 part of the information and services required to be  
55 provided to a Medicaid applicant or recipient under  
56 Section 531.0213, to intervene with "managed care  
57 organizations and providers" on behalf of an  
58 individual with urgent medical needs, and Section  
59 531.0213(d)(6), Government Code, requires the

1 commission to assist "managed care organizations and  
2 providers" in identifying and correcting problems as  
3 part of the information and services. The revised law  
4 substitutes "Medicaid managed care organizations and  
5 providers" for the quoted phrases because it is clear  
6 from the context that the provisions apply only to  
7 managed care organizations and providers  
8 participating in Medicaid.

9 Revised Law

10 Sec. 532.0304. NURSING SERVICES ASSESSMENTS. (a) In this  
11 section, "acute nursing services" means home health skilled nursing  
12 services, home health aide services, and private duty nursing  
13 services.

14 (b) If cost-effective, the commission shall develop an  
15 objective assessment process for use in assessing a recipient's  
16 need for acute nursing services. If the commission develops the  
17 objective assessment process, the commission shall require that:

18 (1) the assessment be conducted:

19 (A) by a state employee or contractor who is a  
20 registered nurse licensed to practice in this state, and who is not:

21 (i) the individual who will deliver any  
22 necessary services to the recipient; or

23 (ii) affiliated with the person who will  
24 deliver those services; and

25 (B) in a timely manner so as to protect the  
26 recipient's health and safety by avoiding unnecessary delays in  
27 service delivery; and

28 (2) the process include:

29 (A) an assessment of specified criteria and  
30 documentation of the assessment results on a standard form;

31 (B) an assessment of whether the recipient should  
32 be referred for additional assessments regarding the recipient's  
33 need for therapy services, as described by Section 532.0305,  
34 attendant care services, and durable medical equipment; and

1 (C) completion by the individual conducting the  
2 assessment of any documents related to obtaining prior  
3 authorization for necessary nursing services.

4 (c) If the commission develops the objective assessment  
5 process under Subsection (b), the commission shall:

6 (1) implement the process within the Medicaid  
7 fee-for-service model and the primary care case management Medicaid  
8 managed care model; and

9 (2) take necessary actions, including modifying  
10 contracts with Medicaid managed care organizations to the extent  
11 allowed by law, to implement the process within the STAR and  
12 STAR+PLUS Medicaid managed care programs.

13 (d) Unless the commission determines that the assessment is  
14 feasible and beneficial, an assessment under Subsection (b)(2)(B)  
15 of whether a recipient should be referred for additional therapy  
16 services assessments shall be waived if the recipient's need for  
17 therapy services has been established by a recommendation from a  
18 therapist providing care before the recipient is discharged from a  
19 licensed hospital or nursing facility. The assessment may not be  
20 waived if the recommendation is made by a therapist who:

21 (1) will deliver any services to the recipient; or

22 (2) is affiliated with a person who will deliver those  
23 services after the recipient is discharged from the licensed  
24 hospital or nursing facility.

25 (e) The executive commissioner shall adopt rules providing  
26 for a process by which a provider of acute nursing services who  
27 disagrees with the results of the assessment conducted under  
28 Subsection (b) may request and obtain a review of those results.  
29 (Gov. Code, Sec. 531.02417.)

30 Source Law

31 Sec. 531.02417. MEDICAID NURSING SERVICES  
32 ASSESSMENTS. (a) In this section, "acute nursing  
33 services" means home health skilled nursing services,  
34 home health aide services, and private duty nursing  
35 services.

36 (b) If cost-effective, the commission shall  
37 develop an objective assessment process for use in

1 assessing a Medicaid recipient's needs for acute  
2 nursing services. If the commission develops an  
3 objective assessment process under this section, the  
4 commission shall require that:

5 (1) the assessment be conducted:

6 (A) by a state employee or contractor  
7 who is a registered nurse who is licensed to practice  
8 in this state and who is not the person who will  
9 deliver any necessary services to the recipient and is  
10 not affiliated with the person who will deliver those  
11 services; and

12 (B) in a timely manner so as to  
13 protect the health and safety of the recipient by  
14 avoiding unnecessary delays in service delivery; and

15 (2) the process include:

16 (A) an assessment of specified  
17 criteria and documentation of the assessment results  
18 on a standard form;

19 (B) an assessment of whether the  
20 recipient should be referred for additional  
21 assessments regarding the recipient's needs for  
22 therapy services, as defined by Section 531.024171,  
23 attendant care services, and durable medical  
24 equipment; and

25 (C) completion by the person  
26 conducting the assessment of any documents related to  
27 obtaining prior authorization for necessary nursing  
28 services.

29 (c) If the commission develops the objective  
30 assessment process under Subsection (b), the  
31 commission shall:

32 (1) implement the process within the  
33 Medicaid fee-for-service model and the primary care  
34 case management Medicaid managed care model; and

35 (2) take necessary actions, including  
36 modifying contracts with managed care organizations  
37 under Chapter 533 to the extent allowed by law, to  
38 implement the process within the STAR and STAR + PLUS  
39 Medicaid managed care programs.

40 (d) Unless the commission determines that the  
41 assessment is feasible and beneficial, an assessment  
42 under Subsection (b)(2)(B) of whether a recipient  
43 should be referred for additional therapy services  
44 shall be waived if the recipient's need for therapy  
45 services has been established by a recommendation from  
46 a therapist providing care prior to discharge of the  
47 recipient from a licensed hospital or nursing home.  
48 The assessment may not be waived if the recommendation  
49 is made by a therapist who will deliver any services to  
50 the recipient or is affiliated with a person who will  
51 deliver those services when the recipient is  
52 discharged from the licensed hospital or nursing home.

53 (e) The executive commissioner shall adopt  
54 rules providing for a process by which a provider of  
55 acute nursing services who disagrees with the results  
56 of the assessment conducted under Subsection (b) may  
57 request and obtain a review of those results.

58 Revisor's Note

59 Section 531.02417(d), Government Code, refers to  
60 a "nursing home." The revised law substitutes  
61 "nursing facility" for "nursing home" because the  
62 terms are synonymous and for consistency of

1 terminology throughout Subtitle I, Title 4, Government  
2 Code, which includes this chapter.

3 Revised Law

4 Sec. 532.0305. THERAPY SERVICES ASSESSMENTS. (a) In this  
5 section, "therapy services" includes occupational, physical, and  
6 speech therapy services.

7 (b) After implementing the objective assessment process for  
8 acute nursing services in accordance with Section 532.0304, the  
9 commission shall consider whether implementing age- and  
10 diagnosis-appropriate objective assessment processes for use in  
11 assessing a recipient's need for therapy services would be feasible  
12 and beneficial.

13 (c) If the commission determines that implementing age- and  
14 diagnosis-appropriate processes with respect to one or more types  
15 of therapy services is feasible and would be beneficial, the  
16 commission may implement the processes within:

17 (1) the Medicaid fee-for-service model;

18 (2) the primary care case management Medicaid managed  
19 care model; and

20 (3) the STAR and STAR+PLUS Medicaid managed care  
21 programs.

22 (d) An objective assessment process implemented under this  
23 section must include a process that allows a therapy services  
24 provider to request and obtain a review of the results of an  
25 assessment conducted as provided by this section. The review  
26 process must be comparable to the review process implemented under  
27 Section 532.0304(e). (Gov. Code, Sec. 531.024171.)

28 Source Law

29 Sec. 531.024171. THERAPY SERVICES ASSESSMENTS.

30 (a) In this section, "therapy services" includes  
31 occupational, physical, and speech therapy services.

32 (b) After implementing the objective assessment  
33 process for acute nursing services in accordance with  
34 Section 531.02417, the commission shall consider  
35 whether implementing age- and diagnosis-appropriate  
36 objective assessment processes for assessing the needs  
37 of a Medicaid recipient for therapy services would be  
38 feasible and beneficial.

39 (c) If the commission determines that

1 implementing age- and diagnosis-appropriate processes  
2 with respect to one or more types of therapy services  
3 is feasible and would be beneficial, the commission  
4 may implement the processes within:

- 5 (1) the Medicaid fee-for-service model;
- 6 (2) the primary care case management  
7 Medicaid managed care model; and
- 8 (3) the STAR and STAR + PLUS Medicaid  
9 managed care programs.

10 (d) An objective assessment process implemented  
11 under this section must include a process that allows a  
12 provider of therapy services to request and obtain a  
13 review of the results of an assessment conducted as  
14 provided by this section that is comparable to the  
15 process implemented under rules adopted under Section  
16 531.02417(e).

17 Revised Law

18 Sec. 532.0306. WELLNESS SCREENING PROGRAM. If  
19 cost-effective, the commission may implement a wellness screening  
20 program for recipients that is designed to evaluate a recipient's  
21 risk for having certain diseases and medical conditions to  
22 establish:

23 (1) a health baseline for each recipient that may be  
24 used to tailor the recipient's treatment plan; or

25 (2) the recipient's health goals. (Gov. Code, Sec.  
26 531.0981.)

27 Source Law

28 Sec. 531.0981. WELLNESS SCREENING PROGRAM. If  
29 cost-effective, the commission may implement a  
30 wellness screening program for Medicaid recipients  
31 designed to evaluate a recipient's risk for having  
32 certain diseases and medical conditions for purposes  
33 of establishing a health baseline for each recipient  
34 that may be used to tailor the recipient's treatment  
35 plan or for establishing the recipient's health goals.

36 Revised Law

37 Sec. 532.0307. FEDERALLY QUALIFIED HEALTH CENTER AND RURAL  
38 HEALTH CLINIC SERVICES. (a) In this section:

39 (1) "Federally qualified health center services" has  
40 the meaning assigned by 42 U.S.C. Section 1396d(1)(2)(A).

41 (2) "Rural health clinic services" has the meaning  
42 assigned by 42 U.S.C. Section 1396d(1)(1).

43 (b) Notwithstanding any provision of this chapter, Chapter  
44 32, Human Resources Code, or any other law, the commission shall:

- 45 (1) promote recipient access to federally qualified

1 health center services or rural health clinic services; and  
2 (2) ensure that payment for federally qualified health  
3 center services or rural health clinic services is in accordance  
4 with 42 U.S.C. Section 1396a(bb). (Gov. Code, Sec. 531.02192(a)  
5 (part), (b).)

6 Source Law

7 Sec. 531.02192. FEDERALLY QUALIFIED HEALTH  
8 CENTER AND RURAL HEALTH CLINIC SERVICES. (a) In this  
9 section:

10 . . .  
11 (2) "Federally qualified health center  
12 services" has the meaning assigned by 42 U.S.C.  
13 Section 1396d(1)(2)(A).

14 . . .  
15 (3) "rural health clinic services"  
16 have the meanings assigned by 42 U.S.C. Section  
17 1396d(1)(1).

18 (b) Notwithstanding any provision of this  
19 chapter, Chapter 32, Human Resources Code, or any  
20 other law, the commission shall:

21 (1) promote Medicaid recipient access to  
22 federally qualified health center services or rural  
23 health clinic services; and

24 (2) ensure that payment for federally  
25 qualified health center services or rural health  
26 clinic services is in accordance with 42 U.S.C.  
27 Section 1396a(bb).

28 Revisor's Note

29 (1) Section 531.02192(a), Government Code,  
30 defines "federally qualified health center,"  
31 "federally qualified health center services," "rural  
32 health clinic," and "rural health clinic services" for  
33 purposes of Section 531.02192, Government Code.  
34 However, "federally qualified health center" is not  
35 used in the section independently from "federally  
36 qualified health center services," and "rural health  
37 clinic" is not used in the section independently from  
38 "rural health clinic services," and the revised law  
39 omits the definitions of those terms as unnecessary.  
40 The omitted law reads:

41 [(a) In this section:]

42 (1) "Federally qualified health  
43 center" has the meaning assigned by 42  
44 U.S.C. Section 1396d(1)(2)(B).

45 . . .  
46 (3) "Rural health clinic" and  
47 . . . [have the meanings assigned by 42  
U.S.C. Section 1396d(1)(1).]



1 (c) If the commission develops tailored benefit packages  
2 under Subsection (b)(2), the commission shall submit to the  
3 standing committees of the senate and house of representatives  
4 having primary jurisdiction over Medicaid a report that specifies  
5 in detail the categories of recipients to which each of those  
6 packages will apply and the services available under each package.

7 (d) Except as otherwise provided by this section and subject  
8 to the terms of the waiver authorized by this section, the  
9 commission has broad discretion to develop the tailored benefit  
10 packages and determine the respective categories of recipients to  
11 which the packages apply in a manner that preserves recipients'  
12 access to necessary services and is consistent with federal  
13 requirements. In developing the tailored benefit packages, the  
14 commission shall consider similar benefit packages established in  
15 other states as a guide.

16 (e) Each tailored benefit package must include:

17 (1) a basic set of benefits that are provided under all  
18 tailored benefit packages;

19 (2) to the extent applicable to the category of  
20 recipients to which the package applies:

21 (A) a set of benefits customized to meet the  
22 health care needs of recipients in that category; and

23 (B) services to integrate the management of a  
24 recipient's acute and long-term care needs, to the extent feasible;  
25 and

26 (3) if the package applies to recipients who are  
27 children, at least the services required by federal law under the  
28 early and periodic screening, diagnosis, and treatment program.

29 (f) A tailored benefit package may include any service  
30 available under the state Medicaid plan or under any federal  
31 Medicaid waiver, including any preventive health or wellness  
32 service.

33 (g) A tailored benefit package must increase this state's  
34 flexibility with respect to the state's use of Medicaid funding and

1 may not reduce the benefits available under the Medicaid state plan  
2 to any recipient population.

3 (h) The executive commissioner by rule shall define each  
4 category of recipients to which a tailored benefit package applies  
5 and a mechanism for appropriately placing recipients in specific  
6 categories. Recipient categories must include children with  
7 special health care needs and may include:

8 (1) individuals with disabilities or special health  
9 care needs;

10 (2) elderly individuals;

11 (3) children without special health care needs; and

12 (4) working-age parents and caretaker relatives.

13 (Gov. Code, Sec. 531.097.)

14 Source Law

15 Sec. 531.097. TAILORED BENEFIT PACKAGES FOR  
16 CERTAIN CATEGORIES OF THE MEDICAID POPULATION. (a)  
17 The executive commissioner may seek a waiver under  
18 Section 1115 of the federal Social Security Act (42  
19 U.S.C. Section 1315) to develop and, subject to  
20 Subsection (c), implement tailored benefit packages  
21 designed to:

22 (1) provide Medicaid benefits that are  
23 customized to meet the health care needs of recipients  
24 within defined categories of the Medicaid population  
25 through a defined system of care;

26 (2) improve health outcomes for those  
27 recipients;

28 (3) improve those recipients' access to  
29 services;

30 (4) achieve cost containment and  
31 efficiency; and

32 (5) reduce the administrative complexity  
33 of delivering Medicaid benefits.

34 (b) The commission:

35 (1) shall develop a tailored benefit  
36 package that is customized to meet the health care  
37 needs of Medicaid recipients who are children with  
38 special health care needs, subject to approval of the  
39 waiver described by Subsection (a); and

40 (2) may develop tailored benefit packages  
41 that are customized to meet the health care needs of  
42 other categories of Medicaid recipients.

43 (c) If the commission develops tailored benefit  
44 packages under Subsection (b)(2), the commission shall  
45 submit a report to the standing committees of the  
46 senate and house of representatives having primary  
47 jurisdiction over Medicaid that specifies, in detail,  
48 the categories of Medicaid recipients to which each of  
49 those packages will apply and the services available  
50 under each package.

51 (d) Except as otherwise provided by this section  
52 and subject to the terms of the waiver authorized by  
53 this section, the commission has broad discretion to

1 develop the tailored benefit packages under this  
2 section and determine the respective categories of  
3 Medicaid recipients to which the packages apply in a  
4 manner that preserves recipients' access to necessary  
5 services and is consistent with federal requirements.

6 (e) Each tailored benefit package developed  
7 under this section must include:

8 (1) a basic set of benefits that are  
9 provided under all tailored benefit packages; and

10 (2) to the extent applicable to the  
11 category of Medicaid recipients to which the package  
12 applies:

13 (A) a set of benefits customized to  
14 meet the health care needs of recipients in that  
15 category; and

16 (B) services to integrate the  
17 management of a recipient's acute and long-term care  
18 needs, to the extent feasible.

19 (f) In addition to the benefits required by  
20 Subsection (e), a tailored benefit package developed  
21 under this section that applies to Medicaid recipients  
22 who are children must provide at least the services  
23 required by federal law under the early and periodic  
24 screening, diagnosis, and treatment program.

25 (g) A tailored benefit package developed under  
26 this section may include any service available under  
27 the state Medicaid plan or under any federal Medicaid  
28 waiver, including any preventive health or wellness  
29 service.

30 (g-1) A tailored benefit package developed  
31 under this section must increase the state's  
32 flexibility with respect to the state's use of Medicaid  
33 funding and may not reduce the benefits available  
34 under the Medicaid state plan to any Medicaid  
35 recipient population.

36 (h) In developing the tailored benefit  
37 packages, the commission shall consider similar  
38 benefit packages established in other states as a  
39 guide.

40 (i) The executive commissioner, by rule, shall  
41 define each category of recipients to which a tailored  
42 benefit package applies and a mechanism for  
43 appropriately placing recipients in specific  
44 categories. Recipient categories must include  
45 children with special health care needs and may  
46 include:

47 (1) persons with disabilities or special  
48 health needs;

49 (2) elderly persons;

50 (3) children without special health care  
51 needs; and

52 (4) working-age parents and caretaker  
53 relatives.

54 Revised Law

55 Sec. 532.0352. WAIVER PROGRAM FOR CERTAIN INDIVIDUALS WITH  
56 CHRONIC HEALTH CONDITIONS. (a) If feasible and cost-effective,  
57 the commission may apply for a waiver from the Centers for Medicare  
58 and Medicaid Services or another appropriate federal agency to more  
59 efficiently leverage the use of state and local money to maximize  
60 the receipt of federal Medicaid matching money by providing

1 Medicaid benefits to individuals who:

2 (1) meet established income and other eligibility  
3 criteria; and

4 (2) are eligible to receive services through the  
5 county for chronic health conditions.

6 (b) In establishing the waiver program, the commission  
7 shall:

8 (1) ensure that this state is a prudent purchaser of  
9 the health care services that are needed for the individuals  
10 described by Subsection (a);

11 (2) solicit broad-based input from interested  
12 persons;

13 (3) ensure that the benefits an individual receives  
14 through the county are not reduced once the individual is enrolled  
15 in the waiver program; and

16 (4) employ the use of intergovernmental transfers and  
17 other procedures to maximize the receipt of federal Medicaid  
18 matching money. (Gov. Code, Sec. 531.0226.)

19 Source Law

20 Sec. 531.0226. CHRONIC HEALTH CONDITIONS  
21 SERVICES MEDICAID WAIVER PROGRAM. (a) If feasible and  
22 cost-effective, the commission may apply for a waiver  
23 from the federal Centers for Medicare and Medicaid  
24 Services or another appropriate federal agency to more  
25 efficiently leverage the use of state and local funds  
26 in order to maximize the receipt of federal Medicaid  
27 matching funds by providing benefits under Medicaid to  
28 individuals who:

29 (1) meet established income and other  
30 eligibility criteria; and

31 (2) are eligible to receive services  
32 through the county for chronic health conditions.

33 (b) In establishing the waiver program under  
34 this section, the commission shall:

35 (1) ensure that the state is a prudent  
36 purchaser of the health care services that are needed  
37 for the individuals described by Subsection (a);

38 (2) solicit broad-based input from  
39 interested persons;

40 (3) ensure that the benefits received by  
41 an individual through the county are not reduced once  
42 the individual is enrolled in the waiver program; and

43 (4) employ the use of intergovernmental  
44 transfers and other procedures to maximize the receipt  
45 of federal Medicaid matching funds.

1 Revised Law

2 Sec. 532.0353. BUY-IN PROGRAMS FOR CERTAIN INDIVIDUALS WITH  
3 DISABILITIES. (a) The executive commissioner shall develop and  
4 implement:

5 (1) a Medicaid buy-in program for individuals with  
6 disabilities as authorized by the Ticket to Work and Work  
7 Incentives Improvement Act of 1999 (Pub. L. No. 106-170) or the  
8 Balanced Budget Act of 1997 (Pub. L. No. 105-33); and

9 (2) a Medicaid buy-in program for children with  
10 disabilities described by 42 U.S.C. Section 1396a(cc)(1) whose  
11 family incomes do not exceed 300 percent of the applicable federal  
12 poverty level, as authorized by the Deficit Reduction Act of 2005  
13 (Pub. L. No. 109-171).

14 (b) The executive commissioner shall adopt rules in  
15 accordance with federal law that provide for:

16 (1) eligibility requirements for each program  
17 described by Subsection (a); and

18 (2) requirements for program participants to pay  
19 premiums or cost-sharing payments, subject to Subsection (c).

20 (c) Rules the executive commissioner adopts under  
21 Subsection (b) with respect to the program for children with  
22 disabilities described by Subsection (a)(2) must require a  
23 participant to pay monthly premiums according to a sliding scale  
24 that is based on family income, subject to the requirements of 42  
25 U.S.C. Sections 1396o(i)(2) and (3). (Gov. Code, Sec. 531.02444.)

26 Source Law

27 Sec. 531.02444. MEDICAID BUY-IN PROGRAMS FOR  
28 CERTAIN PERSONS WITH DISABILITIES. (a) The executive  
29 commissioner shall develop and implement:

30 (1) a Medicaid buy-in program for persons  
31 with disabilities as authorized by the Ticket to Work  
32 and Work Incentives Improvement Act of 1999 (Pub. L.  
33 No. 106-170) or the Balanced Budget Act of 1997 (Pub.  
34 L. No. 105-33); and

35 (2) as authorized by the Deficit Reduction  
36 Act of 2005 (Pub. L. No. 109-171), a Medicaid buy-in  
37 program for children with disabilities that is  
38 described by 42 U.S.C. Section 1396a(cc)(1) whose  
39 family incomes do not exceed 300 percent of the  
40 applicable federal poverty level.

41 (b) The executive commissioner shall adopt

1 rules in accordance with federal law that provide for:  
2 (1) eligibility requirements for each  
3 program described by Subsection (a); and  
4 (2) requirements for participants in the  
5 program to pay premiums or cost-sharing payments,  
6 subject to Subsection (c).  
7 (c) Rules adopted by the executive commissioner  
8 under Subsection (b) with respect to the program for  
9 children with disabilities described by Subsection  
10 (a)(2) must require a participant to pay monthly  
11 premiums according to a sliding scale that is based on  
12 family income, subject to the requirements of 42  
13 U.S.C. Sections 1396o(i)(2) and (3).

14 Revisor's Note

15 Section 531.02444(a)(2), Government Code, refers  
16 to the Medicaid buy-in program for children with  
17 disabilities "that is described by 42 U.S.C. Section  
18 1396a(cc)(1)." 42 U.S.C. Section 1396a(cc)(1)  
19 describes the children with disabilities who are  
20 eligible for the Medicaid buy-in program, not the  
21 program itself. The revised law is drafted  
22 accordingly.

23 SUBCHAPTER I. UTILIZATION REVIEW, PRIOR AUTHORIZATION, AND  
24 COVERAGE PROCESSES AND DETERMINATIONS

25 Revised Law

26 Sec. 532.0401. REVIEW OF PRIOR AUTHORIZATION AND  
27 UTILIZATION REVIEW PROCESSES. The commission shall:

28 (1) in accordance with an established schedule,  
29 periodically review the prior authorization and utilization review  
30 processes within the Medicaid fee-for-service delivery model to  
31 determine whether those processes need modification to reduce  
32 authorizations of unnecessary services and inappropriate use of  
33 services;

34 (2) monitor the prior authorization and utilization  
35 review processes within the Medicaid fee-for-service delivery  
36 model for anomalies and, on identification of an anomaly in a  
37 process, review the process for modification earlier than  
38 scheduled; and

39 (3) monitor Medicaid managed care organizations to  
40 ensure that the organizations are using prior authorization and

1 utilization review processes to reduce authorizations of  
2 unnecessary services and inappropriate use of services. (Gov. Code,  
3 Sec. 531.076.)

4 Source Law

5 Sec. 531.076. REVIEW OF PRIOR AUTHORIZATION AND  
6 UTILIZATION REVIEW PROCESSES. (a) The commission  
7 shall periodically review in accordance with an  
8 established schedule the prior authorization and  
9 utilization review processes within the Medicaid  
10 fee-for-service delivery model to determine if those  
11 processes need modification to reduce authorizations  
12 of unnecessary services and inappropriate use of  
13 services. The commission shall also monitor the  
14 processes described in this subsection for anomalies  
15 and, on identification of an anomaly in a process,  
16 shall review the process for modification earlier than  
17 scheduled.

18 (b) The commission shall monitor Medicaid  
19 managed care organizations to ensure that the  
20 organizations are using prior authorization and  
21 utilization review processes to reduce authorizations  
22 of unnecessary services and inappropriate use of  
23 services.

24 Revised Law

25 Sec. 532.0402. ACCESSIBILITY OF INFORMATION REGARDING  
26 PRIOR AUTHORIZATION REQUIREMENTS. (a) The executive commissioner  
27 by rule shall require each Medicaid managed care organization or  
28 other entity responsible for authorizing coverage for health care  
29 services under Medicaid to ensure that the organization or entity  
30 maintains on the organization's or entity's Internet website in an  
31 easily searchable and accessible format:

32 (1) the applicable timelines for prior authorization  
33 requirements, including:

34 (A) the time within which the organization or  
35 entity must make a determination on a prior authorization request;

36 (B) a description of the notice the organization  
37 or entity provides to a provider and recipient on whose behalf the  
38 request was submitted regarding the documentation required to  
39 complete a determination on a prior authorization request; and

40 (C) the deadline by which the organization or  
41 entity is required to submit the notice described by Paragraph (B);  
42 and

43 (2) an accurate and current catalog of coverage

1 criteria and prior authorization requirements, including:

2 (A) for a prior authorization requirement first  
3 imposed on or after September 1, 2019, the effective date of the  
4 requirement;

5 (B) a list or description of any supporting or  
6 other documentation necessary to obtain prior authorization for a  
7 specified service; and

8 (C) the date and results of each review of a prior  
9 authorization requirement conducted under Section \_\_\_\_\_  
10 [[[Section 533.00283]]], if applicable.

11 (b) The executive commissioner by rule shall require each  
12 Medicaid managed care organization or other entity responsible for  
13 authorizing coverage for health care services under Medicaid to:

14 (1) adopt and maintain a process for a provider or  
15 recipient to contact the organization or entity to clarify prior  
16 authorization requirements or to assist the provider in submitting  
17 a prior authorization request; and

18 (2) ensure that the process described by Subdivision  
19 (1) is not arduous or overly burdensome to a provider or recipient.  
20 (Gov. Code, Sec. 531.024163.)

21 Source Law

22 Sec. 531.024163. ACCESSIBILITY OF INFORMATION  
23 REGARDING MEDICAID PRIOR AUTHORIZATION REQUIREMENTS.

24 (a) The executive commissioner by rule shall require  
25 each Medicaid managed care organization or other  
26 entity responsible for authorizing coverage for health  
27 care services under Medicaid to ensure that the  
28 organization or entity maintains on the organization's  
29 or entity's Internet website in an easily searchable  
30 and accessible format:

31 (1) the applicable timelines for prior  
32 authorization requirements, including:

33 (A) the time within which the  
34 organization or entity must make a determination on a  
35 prior authorization request;

36 (B) a description of the notice the  
37 organization or entity provides to a provider and  
38 Medicaid recipient on whose behalf the request was  
39 submitted regarding the documentation required to  
40 complete a determination on a prior authorization  
41 request; and

42 (C) the deadline by which the  
43 organization or entity is required to submit the  
44 notice described by Paragraph (B); and

45 (2) an accurate and up-to-date catalogue  
46 of coverage criteria and prior authorization

1 requirements, including:

2 (A) for a prior authorization  
3 requirement first imposed on or after September 1,  
4 2019, the effective date of the requirement;

5 (B) a list or description of any  
6 supporting or other documentation necessary to obtain  
7 prior authorization for a specified service; and

8 (C) the date and results of each  
9 review of the prior authorization requirement  
10 conducted under Section 533.00283, if applicable.

11 (b) The executive commissioner by rule shall  
12 require each Medicaid managed care organization or  
13 other entity responsible for authorizing coverage for  
14 health care services under Medicaid to:

15 (1) adopt and maintain a process for a  
16 provider or Medicaid recipient to contact the  
17 organization or entity to clarify prior authorization  
18 requirements or to assist the provider in submitting a  
19 prior authorization request; and

20 (2) ensure that the process described by  
21 Subdivision (1) is not arduous or overly burdensome to  
22 a provider or recipient.

23 Revised Law

24 Sec. 532.0403. NOTICE REQUIREMENTS REGARDING COVERAGE OR  
25 PRIOR AUTHORIZATION DENIAL AND INCOMPLETE REQUESTS. (a) The  
26 commission shall ensure that a notice the commission or a Medicaid  
27 managed care organization sends to a recipient or Medicaid provider  
28 regarding the denial, partial denial, reduction, or termination of  
29 coverage or denial of prior authorization for a service includes:

30 (1) information required by federal and state law and  
31 regulations;

32 (2) for the recipient:

33 (A) a clear and easy-to-understand explanation  
34 of the reason for the decision, including a clear explanation of the  
35 medical basis, applying the policy or accepted standard of medical  
36 practice to the recipient's particular medical circumstances;

37 (B) a copy of the information the commission or  
38 organization sent to the provider; and

39 (C) an educational component that includes:

40 (i) a description of the recipient's  
41 rights;

42 (ii) an explanation of the process related  
43 to appeals and Medicaid fair hearings; and

44 (iii) a description of the role of an  
45 external medical review; and

1 (3) for the provider, a thorough and detailed clinical  
2 explanation of the reason for the decision, including, as  
3 applicable, information required under Subsection (b).

4 (b) The commission or a Medicaid managed care organization  
5 that receives from a provider a coverage or prior authorization  
6 request that contains insufficient or inadequate documentation to  
7 approve the request shall issue a notice to the provider and the  
8 recipient on whose behalf the request was submitted. The notice  
9 must:

10 (1) include a section specifically for the provider  
11 that contains:

12 (A) a clear and specific list and description of  
13 the documentation necessary for the commission or organization to  
14 make a final determination on the request;

15 (B) the applicable timeline, based on the  
16 requested service, for the provider to submit the documentation and  
17 a description of the reconsideration process described by Section  
18 \_\_\_\_\_ [[[Section 533.00284]]], if applicable; and

19 (C) information on the manner through which a  
20 provider may contact a Medicaid managed care organization or other  
21 entity as required by Section 532.0402; and

22 (2) be sent:

23 (A) to the provider:

24 (i) using the provider's preferred method  
25 of communication, to the extent practicable using existing  
26 resources; and

27 (ii) as applicable, through an electronic  
28 notification on an Internet portal; and

29 (B) to the recipient using the recipient's  
30 preferred method of communication, to the extent practicable using  
31 existing resources. (Gov. Code, Sec. 531.024162.)

32 Source Law

33 Sec. 531.024162. NOTICE REQUIREMENTS REGARDING  
34 MEDICAID COVERAGE OR PRIOR AUTHORIZATION DENIAL AND  
35 INCOMPLETE REQUESTS. (a) The commission shall ensure

1 that notice sent by the commission or a Medicaid  
2 managed care organization to a Medicaid recipient or  
3 provider regarding the denial, partial denial,  
4 reduction, or termination of coverage or denial of  
5 prior authorization for a service includes:

6 (1) information required by federal and  
7 state law and applicable regulations;

8 (2) for the recipient:

9 (A) a clear and easy-to-understand  
10 explanation of the reason for the decision, including  
11 a clear explanation of the medical basis, applying the  
12 policy or accepted standard of medical practice to the  
13 recipient's particular medical circumstances;

14 (B) a copy of the information sent to  
15 the provider; and

16 (C) an educational component that  
17 includes a description of the recipient's rights, an  
18 explanation of the process related to appeals and  
19 Medicaid fair hearings, and a description of the role  
20 of an external medical review; and

21 (3) for the provider, a thorough and  
22 detailed clinical explanation of the reason for the  
23 decision, including, as applicable, information  
24 required under Subsection (b).

25 (b) The commission or a Medicaid managed care  
26 organization that receives from a provider a coverage  
27 or prior authorization request that contains  
28 insufficient or inadequate documentation to approve  
29 the request shall issue a notice to the provider and  
30 the Medicaid recipient on whose behalf the request was  
31 submitted. The notice issued under this subsection  
32 must:

33 (1) include a section specifically for the  
34 provider that contains:

35 (A) a clear and specific list and  
36 description of the documentation necessary for the  
37 commission or organization to make a final  
38 determination on the request;

39 (B) the applicable timeline, based on  
40 the requested service, for the provider to submit the  
41 documentation and a description of the reconsideration  
42 process described by Section 533.00284, if applicable;  
43 and

44 (C) information on the manner through  
45 which a provider may contact a Medicaid managed care  
46 organization or other entity as required by Section  
47 531.024163; and

48 (2) be sent:

49 (A) to the provider:

50 (i) using the provider's  
51 preferred method of communication, to the extent  
52 practicable using existing resources; and

53 (ii) as applicable, through an  
54 electronic notification on an Internet portal; and

55 (B) to the recipient using the  
56 recipient's preferred method of communication, to the  
57 extent practicable using existing resources.

58 Revised Law

59 Sec. 532.0404. EXTERNAL MEDICAL REVIEW. (a) In this  
60 section, "external medical reviewer" means a third-party medical  
61 review organization that provides objective, unbiased medical  
62 necessity determinations conducted by clinical staff with

1 education and practice in the same or similar practice area as the  
2 procedure for which an independent determination of medical  
3 necessity is sought in accordance with state law and rules.

4 (b) The commission shall contract with an independent  
5 external medical reviewer to conduct external medical reviews and  
6 review:

7 (1) the resolution of a recipient appeal related to a  
8 reduction in or denial of services on the basis of medical necessity  
9 in the Medicaid managed care program; or

10 (2) the commission's denial of eligibility for a  
11 Medicaid program in which eligibility is based on a recipient's  
12 medical and functional needs.

13 (c) A Medicaid managed care organization may not have a  
14 financial relationship with or ownership interest in the external  
15 medical reviewer with which the commission contracts.

16 (d) The external medical reviewer with which the commission  
17 contracts must:

18 (1) be overseen by a medical director who is a  
19 physician licensed in this state; and

20 (2) employ or be able to consult with staff with  
21 experience in providing private duty nursing services and long-term  
22 services and supports.

23 (e) The commission shall establish:

24 (1) a common procedure for external medical reviews  
25 that:

26 (A) to the greatest extent possible, reduces:

27 (i) administrative burdens on providers;

28 and

29 (ii) the submission of duplicative  
30 information or documents; and

31 (B) bases a medical necessity determination on  
32 clinical criteria that is:

33 (i) publicly available;

34 (ii) current;

1 (iii) evidence-based; and  
2 (iv) peer-reviewed; and  
3 (2) a procedure and time frame for expedited reviews  
4 that allow the external medical reviewer to:  
5 (A) identify an appeal that requires an expedited  
6 resolution; and  
7 (B) resolve the review of the appeal within a  
8 specified period.  
9 (f) The external medical reviewer shall conduct an external  
10 medical review within a period the commission specifies.  
11 (g) A recipient or Medicaid applicant, or the recipient's or  
12 applicant's parent or legally authorized representative, must  
13 affirmatively request an external medical review. If requested:  
14 (1) an external medical review described by Subsection  
15 (b)(1):  
16 (A) occurs after the internal Medicaid managed  
17 care organization appeal and before the Medicaid fair hearing; and  
18 (B) is granted when a recipient contests the  
19 internal appeal decision of the Medicaid managed care organization;  
20 and  
21 (2) an external medical review described by Subsection  
22 (b)(2) occurs after the eligibility denial and before the Medicaid  
23 fair hearing.  
24 (h) The external medical reviewer's determination of  
25 medical necessity establishes the minimum level of services a  
26 recipient must receive, except that the level of services may not  
27 exceed the level identified as medically necessary by the ordering  
28 health care provider.  
29 (i) The external medical reviewer shall require a Medicaid  
30 managed care organization, in an external medical review relating  
31 to a reduction in services, to submit a detailed reason for the  
32 reduction and supporting documents.  
33 (j) To the extent money is appropriated for this purpose,  
34 the commission shall publish data regarding prior authorizations

1 the external medical reviewer reviewed, including the rate of prior  
2 authorization denials the external medical reviewer overturned and  
3 additional information the commission and the external medical  
4 reviewer determine appropriate. (Gov. Code, Sec. 531.024164.)

5 Source Law

6 Sec. 531.024164. EXTERNAL MEDICAL REVIEW.

7 (a) In this section, "external medical reviewer" and  
8 "reviewer" mean a third-party medical review  
9 organization that provides objective, unbiased  
10 medical necessity determinations conducted by  
11 clinical staff with education and practice in the same  
12 or similar practice area as the procedure for which an  
13 independent determination of medical necessity is  
14 sought in accordance with applicable state law and  
15 rules.

16 (b) The commission shall contract with an  
17 independent external medical reviewer to conduct  
18 external medical reviews and review:

19 (1) the resolution of a Medicaid recipient  
20 appeal related to a reduction in or denial of services  
21 on the basis of medical necessity in the Medicaid  
22 managed care program; or

23 (2) a denial by the commission of  
24 eligibility for a Medicaid program in which  
25 eligibility is based on a Medicaid recipient's medical  
26 and functional needs.

27 (c) A Medicaid managed care organization may not  
28 have a financial relationship with or ownership  
29 interest in the external medical reviewer with which  
30 the commission contracts.

31 (d) The external medical reviewer with which the  
32 commission contracts must:

33 (1) be overseen by a medical director who  
34 is a physician licensed in this state; and

35 (2) employ or be able to consult with staff  
36 with experience in providing private duty nursing  
37 services and long-term services and supports.

38 (e) The commission shall establish a common  
39 procedure for reviews. To the greatest extent  
40 possible, the procedure must reduce administrative  
41 burdens on providers and the submission of duplicative  
42 information or documents. Medical necessity under  
43 the procedure must be based on publicly available,  
44 up-to-date, evidence-based, and peer-reviewed  
45 clinical criteria. The reviewer shall conduct the  
46 review within a period specified by the  
47 commission. The commission shall also establish a  
48 procedure and time frame for expedited reviews that  
49 allows the reviewer to:

50 (1) identify an appeal that requires an  
51 expedited resolution; and

52 (2) resolve the review of the appeal  
53 within a specified period.

54 (f) A Medicaid recipient or applicant, or the  
55 recipient's or applicant's parent or legally  
56 authorized representative, must affirmatively request  
57 an external medical review. If requested:

58 (1) an external medical review described  
59 by Subsection (b)(1) occurs after the internal  
60 Medicaid managed care organization appeal and before  
61 the Medicaid fair hearing and is granted when a  
62 Medicaid recipient contests the internal appeal

1 decision of the Medicaid managed care organization;  
2 and

3 (2) an external medical review described  
4 by Subsection (b)(2) occurs after the eligibility  
5 denial and before the Medicaid fair hearing.

6 (g) The external medical reviewer's  
7 determination of medical necessity establishes the  
8 minimum level of services a Medicaid recipient must  
9 receive, except that the level of services may not  
10 exceed the level identified as medically necessary by  
11 the ordering health care provider.

12 (h) The external medical reviewer shall require  
13 a Medicaid managed care organization, in an external  
14 medical review relating to a reduction in services, to  
15 submit a detailed reason for the reduction and  
16 supporting documents.

17 (i) To the extent money is appropriated for this  
18 purpose, the commission shall publish data regarding  
19 prior authorizations reviewed by the external medical  
20 reviewer, including the rate of prior authorization  
21 denials overturned by the external medical reviewer  
22 and additional information the commission and the  
23 external medical reviewer determine appropriate.

## 24 SUBCHAPTER J. COST-SAVING INITIATIVES

### 25 Revised Law

26 Sec. 532.0451. HOSPITAL EMERGENCY ROOM USE REDUCTION  
27 INITIATIVES. (a) The commission shall develop and implement a  
28 comprehensive plan to reduce recipients' use of hospital emergency  
29 room services. The plan may include:

30 (1) a pilot program that is designed to assist a  
31 program participant in accessing an appropriate level of health  
32 care and that may include as components:

33 (A) providing a program participant access to  
34 bilingual health services providers; and

35 (B) giving a program participant information on  
36 how to access primary care physicians, advanced practice registered  
37 nurses, and local health clinics;

38 (2) a pilot program under which a health care provider  
39 other than a hospital is given a financial incentive for treating a  
40 recipient outside of normal business hours to divert the recipient  
41 from a hospital emergency room;

42 (3) payment of a nominal referral fee to a hospital  
43 emergency room that performs an initial medical evaluation of a  
44 recipient and subsequently refers the recipient, if medically  
45 stable, to an appropriate level of health care, such as care

1 provided by a primary care physician, advanced practice registered  
2 nurse, or local clinic;

3 (4) a program under which the commission or a Medicaid  
4 managed care organization contacts, by telephone or mail, a  
5 recipient who accesses a hospital emergency room three times during  
6 a six-month period and provides the recipient with information on  
7 ways the recipient may secure a medical home to avoid unnecessary  
8 treatment at a hospital emergency room;

9 (5) a health care literacy program under which the  
10 commission develops partnerships with other state agencies and  
11 private entities to:

12 (A) assist the commission in developing  
13 materials that:

14 (i) contain basic health care information  
15 for parents of young children who are recipients and who are  
16 participating in public or private child-care or prekindergarten  
17 programs, including federal Head Start programs; and

18 (ii) are written in a language  
19 understandable to those parents and specifically tailored to be  
20 applicable to the needs of those parents;

21 (B) distribute the materials developed under  
22 Paragraph (A) to those parents; and

23 (C) otherwise teach those parents about their  
24 children's health care needs and ways to address those needs; and

25 (6) other initiatives developed and implemented in  
26 other states that have shown success in reducing the incidence of  
27 unnecessary treatment in a hospital emergency room.

28 (b) The commission shall coordinate with hospitals and  
29 other providers that receive supplemental payments under the  
30 uncompensated care payment program operated under the Texas Health  
31 Care Transformation and Quality Improvement Program waiver issued  
32 under Section 1115 of the Social Security Act (42 U.S.C. Section  
33 1315) to identify and implement initiatives based on best practices  
34 and models that are designed to reduce recipients' use of hospital

1 emergency room services as a primary means of receiving health care  
2 benefits, including initiatives designed to improve recipients'  
3 access to and use of primary care providers. (Gov. Code, Sec.  
4 531.085.)

5 Source Law

6 Sec. 531.085. HOSPITAL EMERGENCY ROOM USE  
7 REDUCTION INITIATIVES. (a) The commission shall  
8 develop and implement a comprehensive plan to reduce  
9 the use of hospital emergency room services by  
10 recipients under Medicaid. The plan may include:

11 (1) a pilot program designed to facilitate  
12 program participants in accessing an appropriate level  
13 of health care, which may include as components:

14 (A) providing program participants  
15 access to bilingual health services providers; and

16 (B) giving program participants  
17 information on how to access primary care physicians,  
18 advanced practice registered nurses, and local health  
19 clinics;

20 (2) a pilot program under which health  
21 care providers, other than hospitals, are given  
22 financial incentives for treating recipients outside  
23 of normal business hours to divert those recipients  
24 from hospital emergency rooms;

25 (3) payment of a nominal referral fee to  
26 hospital emergency rooms that perform an initial  
27 medical evaluation of a recipient and subsequently  
28 refer the recipient, if medically stable, to an  
29 appropriate level of health care, such as care  
30 provided by a primary care physician, advanced  
31 practice registered nurse, or local clinic;

32 (4) a program under which the commission  
33 or a managed care organization that enters into a  
34 contract with the commission under Chapter 533  
35 contacts, by telephone or mail, a recipient who  
36 accesses a hospital emergency room three times during  
37 a six-month period and provides the recipient with  
38 information on ways the recipient may secure a medical  
39 home to avoid unnecessary treatment at hospital  
40 emergency rooms;

41 (5) a health care literacy program under  
42 which the commission develops partnerships with other  
43 state agencies and private entities to:

44 (A) assist the commission in  
45 developing materials that:

46 (i) contain basic health care  
47 information for parents of young children who are  
48 recipients under Medicaid and who are participating in  
49 public or private child-care or prekindergarten  
50 programs, including federal Head Start programs; and

51 (ii) are written in a language  
52 understandable to those parents and specifically  
53 tailored to be applicable to the needs of those  
54 parents;

55 (B) distribute the materials  
56 developed under Paragraph (A) to those parents; and

57 (C) otherwise teach those parents  
58 about the health care needs of their children and ways  
59 to address those needs; and

60 (6) other initiatives developed and  
61 implemented in other states that have shown success in  
62 reducing the incidence of unnecessary treatment in

1 hospital emergency rooms.

2 (b) The commission shall coordinate with  
3 hospitals and other providers that receive  
4 supplemental payments under the uncompensated care  
5 payment program operated under the Texas Health Care  
6 Transformation and Quality Improvement Program waiver  
7 issued under Section 1115 of the federal Social  
8 Security Act (42 U.S.C. Section 1315) to identify and  
9 implement initiatives based on best practices and  
10 models that are designed to reduce Medicaid  
11 recipients' use of hospital emergency room services as  
12 a primary means of receiving health care benefits,  
13 including initiatives designed to improve recipients'  
14 access to and use of primary care providers.

15 Revised Law

16 Sec. 532.0452. PHYSICIAN INCENTIVE PROGRAM TO REDUCE  
17 HOSPITAL EMERGENCY ROOM USE FOR NON-EMERGENT CONDITIONS. (a) If  
18 cost-effective, the executive commissioner by rule shall establish  
19 a physician incentive program designed to reduce recipients' use of  
20 hospital emergency room services for non-emergent conditions.

21 (b) In establishing the physician incentive program, the  
22 executive commissioner may include only the program components  
23 identified as cost-effective in the study conducted under former  
24 Section 531.086 before that section expired September 1, 2014.

25 (c) If the physician incentive program includes the payment  
26 of an enhanced reimbursement rate for routine after-hours  
27 appointments, the executive commissioner shall implement controls  
28 to ensure that the after-hours services billed are actually  
29 provided outside of normal business hours. (Gov. Code, Sec.  
30 531.0861.)

31 Source Law

32 Sec. 531.0861. PHYSICIAN INCENTIVE PROGRAM TO  
33 REDUCE HOSPITAL EMERGENCY ROOM USE FOR NON-EMERGENT  
34 CONDITIONS. (a) If cost-effective, the executive  
35 commissioner by rule shall establish a physician  
36 incentive program designed to reduce the use of  
37 hospital emergency room services for non-emergent  
38 conditions by recipients under Medicaid.

39 (b) In establishing the physician incentive  
40 program under Subsection (a), the executive  
41 commissioner may include only the program components  
42 identified as cost-effective in the study conducted  
43 under former Section 531.086.

44 (c) If the physician incentive program includes  
45 the payment of an enhanced reimbursement rate for  
46 routine after-hours appointments, the executive  
47 commissioner shall implement controls to ensure that  
48 the after-hours services billed are actually being  
49 provided outside of normal business hours.

1 Revisor's Note

2 Section 531.0861(b), Government Code, refers to a  
3 study conducted under "former Section 531.086,"  
4 Government Code. Section 531.086 required the Health  
5 and Human Services Commission to conduct a study to  
6 evaluate physician incentive programs that attempt to  
7 reduce Medicaid recipients' hospital emergency room  
8 use for non-emergent conditions. Section 531.086(d)  
9 provided that the section expired September 1, 2014.  
10 The revised law includes a reference to the expiration  
11 date for the convenience of the reader.

12 Revised Law

13 Sec. 532.0453. CONTINUED IMPLEMENTATION OF CERTAIN  
14 INTERVENTIONS AND BEST PRACTICES BY PROVIDERS; SEMIANNUAL REPORT.

15 (a) The commission shall encourage Medicaid providers to continue  
16 implementing effective interventions and best practices associated  
17 with improvements in the health outcomes of recipients that were  
18 developed and achieved under the Delivery System Reform Incentive  
19 Payment (DSRIP) program previously operated under the Texas Health  
20 Care Transformation and Quality Improvement Program waiver issued  
21 under Section 1115 of the Social Security Act (42 U.S.C. Section  
22 1315), through:

23 (1) existing provider incentive programs and the  
24 creation of new provider incentive programs;

25 (2) the terms included in contracts with Medicaid  
26 managed care organizations;

27 (3) implementation of alternative payment models; or

28 (4) adoption of other cost-effective measures.

29 (b) The commission shall semiannually prepare and submit to  
30 the legislature a report that contains a summary of the  
31 commission's efforts under this section and Section 532.0451(b).  
32 (Gov. Code, Sec. 531.0862.)

33 Source Law

34 Sec. 531.0862. CONTINUED IMPLEMENTATION OF

1 CERTAIN INTERVENTIONS AND BEST PRACTICES BY PROVIDERS;  
2 BIENNIAL REPORT. (a) The commission shall encourage  
3 Medicaid providers to continue implementing effective  
4 interventions and best practices associated with  
5 improvements in the health outcomes of Medicaid  
6 recipients that were developed and achieved under the  
7 Delivery System Reform Incentive Payment (DSRIP)  
8 program previously operated under the Texas Health  
9 Care Transformation and Quality Improvement Program  
10 waiver issued under Section 1115 of the federal Social  
11 Security Act (42 U.S.C. Section 1315), through:

12 (1) existing provider incentive programs  
13 and the creation of new provider incentive programs;

14 (2) the terms included in contracts with  
15 Medicaid managed care organizations;

16 (3) implementation of alternative payment  
17 models; or

18 (4) adoption of other cost-effective  
19 measures.

20 (b) The commission shall biennially prepare and  
21 submit a report to the legislature that contains a  
22 summary of the commission's efforts under this section  
23 and Section 531.085(b).

24 Revised Law

25 Sec. 532.0454. HEALTH SAVINGS ACCOUNT PILOT PROGRAM. (a)

26 If the commission determines that it is cost-effective and  
27 feasible, the commission shall develop and implement a Medicaid  
28 health savings account pilot program that is consistent with  
29 federal law to:

30 (1) encourage adult recipients' health care cost  
31 awareness and sensitivity; and

32 (2) promote adult recipients' appropriate use of  
33 Medicaid services.

34 (b) If the commission implements the pilot program, the  
35 commission:

36 (1) may include only adult recipients as program  
37 participants; and

38 (2) shall ensure that:

39 (A) participation in the pilot program is  
40 voluntary; and

41 (B) a recipient who participates in the pilot  
42 program may, at the recipient's option and subject to Subsection  
43 (c), discontinue participating and resume receiving benefits and  
44 services under the traditional Medicaid delivery model.

45 (c) A recipient who chooses to discontinue participating in

1 the pilot program and resume receiving benefits and services under  
2 the traditional Medicaid delivery model before completion of the  
3 health savings account enrollment period forfeits any money  
4 remaining in the recipient's health savings account. (Gov. Code,  
5 Sec. 531.0941.)

6 Source Law

7 Sec. 531.0941. MEDICAID HEALTH SAVINGS ACCOUNT  
8 PILOT PROGRAM. (a) If the commission determines that  
9 it is cost-effective and feasible, the commission  
10 shall develop and implement a Medicaid health savings  
11 account pilot program that is consistent with federal  
12 law to:

13 (1) encourage health care cost awareness  
14 and sensitivity by adult recipients; and

15 (2) promote appropriate utilization of  
16 Medicaid services by adult recipients.

17 (b) If the commission implements the pilot  
18 program, the commission may only include adult  
19 recipients as participants in the program.

20 (c) If the commission implements the pilot  
21 program, the commission shall ensure that:

22 (1) participation in the pilot program is  
23 voluntary; and

24 (2) a recipient who participates in the  
25 pilot program may, at the recipient's option and  
26 subject to Subsection (d), discontinue participation  
27 in the program and resume receiving benefits and  
28 services under the traditional Medicaid delivery  
29 model.

30 (d) A recipient who chooses to discontinue  
31 participation in the pilot program and resume  
32 receiving benefits and services under the traditional  
33 Medicaid delivery model before completion of the  
34 health savings account enrollment period forfeits any  
35 funds remaining in the recipient's health savings  
36 account.

37 Revised Law

38 Sec. 532.0455. DURABLE MEDICAL EQUIPMENT REUSE PROGRAM.

39 (a) In this section:

40 (1) "Complex rehabilitation technology equipment":

41 (A) means equipment that is:

42 (i) classified as durable medical equipment  
43 under the Medicare program on January 1, 2013;

44 (ii) configured specifically for an  
45 individual to meet the individual's unique medical, physical, and  
46 functional needs and capabilities for basic and instrumental daily  
47 living activities; and

48 (iii) medically necessary to prevent the

1 individual's hospitalization or institutionalization; and

2 (B) includes a complex rehabilitation power  
3 wheelchair, highly configurable manual wheelchair, adaptive  
4 seating and positioning system, standing frame, and gait trainer.

5 (2) "Durable medical equipment" means equipment,  
6 including repair and replacement parts for the equipment, but  
7 excluding complex rehabilitation technology equipment, that:

8 (A) can withstand repeated use;

9 (B) is primarily and customarily used to serve a  
10 medical purpose;

11 (C) generally is not useful to an individual in  
12 the absence of illness or injury; and

13 (D) is appropriate and safe for use in the home.

14 (b) If the commission determines that it is cost-effective,  
15 the executive commissioner by rule shall establish a program to  
16 facilitate the reuse of durable medical equipment provided to  
17 recipients.

18 (c) The program must include provisions for ensuring that:

19 (1) reused equipment meets applicable standards of  
20 functionality and sanitation; and

21 (2) a recipient's participation in the reuse program  
22 is voluntary.

23 (d) The program does not:

24 (1) waive any immunity from liability of the  
25 commission or a commission employee; or

26 (2) create a cause of action against the commission or  
27 a commission employee arising from the provision of reused durable  
28 medical equipment under the program. (Gov. Code, Secs.  
29 531.0843(a), (b), (c), (d).)

30 Source Law

31 Sec. 531.0843. DURABLE MEDICAL EQUIPMENT REUSE  
32 PROGRAM. (a) In this section:

33 (1) "Complex rehabilitation technology  
34 equipment" means equipment that is classified as  
35 durable medical equipment under the Medicare program  
36 on January 1, 2013, configured specifically for an  
37 individual to meet the individual's unique medical,

1 physical, and functional needs and capabilities for  
2 basic and instrumental daily living activities, and  
3 medically necessary to prevent the individual's  
4 hospitalization or institutionalization. The term  
5 includes a complex rehabilitation power wheelchair,  
6 highly configurable manual wheelchair, adaptive  
7 seating and positioning system, standing frame, and  
8 gait trainer.

9 (2) "Durable medical equipment" means  
10 equipment, including repair and replacement parts for  
11 the equipment, but excluding complex rehabilitation  
12 technology equipment, that:

13 (A) can withstand repeated use;

14 (B) is primarily and customarily used  
15 to serve a medical purpose;

16 (C) generally is not useful to a  
17 person in the absence of illness or injury; and

18 (D) is appropriate and safe for use  
19 in the home.

20 (b) If the commission determines that it is  
21 cost-effective, the executive commissioner by rule  
22 shall establish a program to facilitate the reuse of  
23 durable medical equipment provided to recipients under  
24 the Medicaid program.

25 (c) The program must include provisions for  
26 ensuring that:

27 (1) reused equipment meets applicable  
28 standards of functionality and sanitation; and

29 (2) a Medicaid recipient's participation  
30 in the reuse program is voluntary.

31 (d) The program does not:

32 (1) waive any immunity from liability of  
33 the commission or an employee of the commission; or

34 (2) create a cause of action against the  
35 commission or an employee of the commission arising  
36 from the provision of reused durable medical equipment  
37 under the program.

#### 38 Revisor's Note

39 Section 531.0843(e), Government Code, requires  
40 the executive commissioner of the Health and Human  
41 Services Commission to provide notice of each proposed  
42 rule, adopted rule, and hearing in accordance with  
43 Chapter 551 or 2001, Government Code, as applicable.  
44 Chapter 551, Government Code, requires a governmental  
45 body to give notice of each meeting held by the  
46 governmental body. See Section 551.041, Government  
47 Code. Section 551.001 of that chapter defines  
48 "governmental body" for purposes of the chapter in a  
49 manner that includes the Health and Human Services  
50 Commission. Chapter 2001, Government Code, requires a  
51 state agency to give notice of proposed rules and to  
52 file adopted rules with the office of the secretary of

1 state for publication in the Texas Register. See  
2 Sections 2001.023 and 2001.036(c), Government Code.  
3 Section 2001.003 of that chapter defines "state  
4 agency" for purposes of the chapter in a manner that  
5 includes the Health and Human Services Commission. The  
6 notice requirements of Chapters 551 and 2001 apply by  
7 their own terms. Therefore, the revised law omits the  
8 requirements of Section 531.0843(e) as unnecessary.  
9 The omitted law reads:

10 (e) In accordance with Chapter 551 or  
11 2001, as applicable, the executive  
12 commissioner shall provide notice of each  
13 proposed rule, adopted rule, and hearing  
14 that relates to establishing the program  
15 under this section.